M

I

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

07864

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY a a MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place) 25 Days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Anne Arundel Gen Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY a a
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Edgewater
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print) (First) Ida (Middle) a (Last) affayroux
4. DATE OF DEATH (Month) Aug (Day) 8 (Year) 1950
5. SEX F
6. COLOR OR RACE w
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) W
8. DATE OF BIRTH Oct 1-1867
9. AGE last birthday 82 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Balto Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Jesse T. Merrick
14. MOTHER'S MAIDEN NAME Amelia Howard
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Ethel M Galloway

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a)	Hepatitis, Chronic	3 wks.
157X Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	Carcinoma of Pancreas	3 wks.
46g	(c)	Senility	1 yr.

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7-14-, 1950, to 8-8-, 1950, that I last saw the deceased alive on 8-8-, 1950, and that death occurred at 12 50 p.m., from the causes and on the date stated above.

SIGNATURE James R. Martin (Degree or title) M.D. ADDRESS Annapolis, Md. DATE SIGNED 8-8-50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF Aug 11, 1950
NAME OF CEMETERY OR CREMATORY Baltimore Con
LOCATION (City, town, or county) Baltimore Md (State)
DATE REC'D BY LOCAL REG. 8/9/50
REGISTRAR'S SIGNATURE G. W. Hedrick
24. FUNERAL DIRECTOR Ulbrich Funeral Home ADDRESS 7008 Orleans St

JT

Evidence for addition of 4 [redacted] as per phone call of funeral director [redacted] AUG 29 1950

M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

07865

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Millersville — LENGTH OF STAY (in this place) 27 yrs	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Millersville
HOSPITAL OR INSTITUTION OR STREET ADDRESS	STREET ADDRESS (If rural give location) Crain Highway

3. NAME OF DECEASED (Type or Print) (First) CATHERN	(Middle) M	(Last) BACH	4. DATE OF DEATH (Month) Aug (Day) 27	(Year) 1950
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH Aug 31, 1880	9. AGE last birthday 69 yrs. — If under 1 year: Months, Days — If under 24 hrs.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife	10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (State or foreign country) Baltimore Md	12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME George W. Vermillion		14. MOTHER'S MAIDEN NAME Cathern M. Benson		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) — (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Lorenz H. Bach		

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
443x Immediate cause	(a) Cardio-Vascular Disease	5 yrs.
93d Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Arterio-Sclerosis + Hypertension	10 yrs.
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb., 1944, to Aug. 27, 1950, that I last saw the deceased alive on Aug. 27, 1950, and that death occurred at 9:40 P.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Chas. L. Ball Jr.	MD	Linthicum	Md.

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF Aug 30. 1950	NAME OF CEMETERY OR CREMATORY Cedar Hill	LOCATION (City, town, or county) A.A. Co. (State) Md
DATE REC'D BY LOCAL REG. Aug 29, 1950	REGISTRAR'S SIGNATURE [signature] ms	24. FUNERAL DIRECTOR Mr & Mrs. John W. Teufel & Son	ADDRESS 5311 Edmondson Ave

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 07866

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH
COUNTY A.A. Co. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Riverdale Md. | LENGTH OF STAY (in this place) 2 mo
HOSPITAL OR INSTITUTION OR STREET ADDRESS 10 Eugenia Ave

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland COUNTY A.A Co
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Glen Burnie Md.
STREET ADDRESS (If rural, give location) 410 Maple Lane N.W.

3. NAME OF DECEASED (Type or Print): (First) Barbara (Middle) Elizabeth (Last) Baker

4. DATE OF DEATH: (Month) 8 (Day) 26 (Year) 1950

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Single

8. DATE OF BIRTH: 1/9/1936

9. AGE last birthday: 14 yrs. | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): School Girl

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore Md.

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: James H. Baker 3rd

14. MOTHER'S MAIDEN NAME: Lettie Braun

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): — | (If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: —

17. INFORMANT: Mrs Lettie Baker

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

193X Immediate cause (a) Glioblastoma — Interval between onset and death: 7 wks.

54a Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at 10 25 A.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED
Charles R. MacDonald MD Glen Burnie Md.

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE THEREOF 8/29/50 | NAME OF CEMETERY OR CREMATORY: Glen Haven Mem. Pk. | LOCATION (City, town, or county) (State): Ritchie Hgwy Md.

DATE REC'D BY LOCAL REG. 8/28/50 | REGISTRAR'S SIGNATURE Dan Hedrick Dep | 24. FUNERAL DIRECTOR: John J. Govan & Son | ADDRESS: 90 Rollins St.

M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 07867 28

1. PLACE OF DEATH · COUNTY Anne Arundel MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Crownsville — LENGTH OF STAY (in this place) 13 months	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Crownsville
HOSPITAL OR INSTITUTION OR STREET ADDRESS	STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)	(First) Margaret	(Middle)	(Last) Benedict	4. DATE OF DEATH	(Month) August (Day) 31 (Year) 1950
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 12/15/77	9. AGE last birthday 72 yrs.	If under 1 year Months Days; If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Prague, C. S. R.	12. CITIZEN OF WHAT COUNTRY? Stateless	
13. FATHER'S NAME Dr. Ludwig Kahn			14. MOTHER'S MAIDEN NAME Anna Katz		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS Dr. Ludwig Benedict, Son-Crownsville, Md.		

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
422.2 Immediate cause	(a) Chronic myocarditis	6 months
932 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Generalized Osteporosis	18 months
	(c)	

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/10, 1949, to August 31 1950, that I last saw the deceased alive on 8/31/, 1950, and that death occurred at 3:05 p. m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Jacob Morgenstern	M. D.	Crownsville, Maryland	8/31/50

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Cremation	Sept 1, 1950	Loudon Park	Frederick Rd	Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
9/1/50	H. W. Hedrick Dep	David Sondheim's Son 1902	Eutaw

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VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

67868

Reg. Dist. No. 28

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Gambrills, Md
LENGTH OF STAY (In this place) 20 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Gambrills near Annapolis

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY A.A. Co
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Gambrills-near Annapolis
STREET ADDRESS (If rural, give location) Gambrills near Annapolis

3. NAME OF DECEASED (Type or Print) (First) George (Middle) Vias (Last) Bias
4. DATE OF DEATH (Month) 8 (Day) 12 (Year) 1950

5. SEX male
6. COLOR OR RACE Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single
8. DATE OF BIRTH 9/1/1918
9. AGE last birthday 31 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver
10b. KIND OF BUSINESS OR INDUSTRY Saw Mill. None
11. BIRTHPLACE (State or foreign country) Clonedconnelle
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Richard Bias
14. MOTHER'S MAIDEN NAME Hattie Johnson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY No. 218-16-2577
17. INFORMANT Hattie Johnson Bias

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

982X Immediate cause (a) Severed Jugular Vein c̄

167 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Secondary Hemorrhage.

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☑ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY Rossbark Saw Mill.
(CITY OR TOWN) Gambrills. (COUNTY) AACO. (STATE) Md
TIME OF INJURY (Month) 8 (Day) 12 (Year) 1950 (Hour) P m.
INJURY OCCURRED While at work ☐ Not while at work ☑
HOW DID INJURY OCCUR? Stabbed-p

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☑ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐.*

SIGNATURE Elm Leidt (Degree or title) MD ADDRESS Easport, Md. DATE SIGNED 8/16/50

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF 8/16/50
NAME OF CEMETERY OR CREMATORY Davidsonville
LOCATION (City, town, or county) Davidsonville (State) Md.

DATE REC'D BY LOCAL REG. August 16, 1950
REGISTRAR'S SIGNATURE M. E. Joyce
24. FUNERAL DIRECTOR Mrs. Chas. E. Kirk & Son ADDRESS 42009 Annapolis, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
SEP 6 1950
BUREAU V. S

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

07869

Reg. Dist. No. 22

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Jessup
LENGTH OF STAY (in this place) 6 Days
HOSPITAL OR INSTITUTION OR STREET ADDRESS MHC Jessup, Maryland

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore
STREET ADDRESS (If rural, give location) 939 Sommerset Street ✓

3. NAME OF DECEASED (Type or Print) (First) Clinton (Middle) NMN (Last) Booth
4. DATE OF DEATH (Month) August (Day) 8 (Year) 1950

5. SEX Male
6. COLOR OR RACE Negro
7. ~~SINGLE,~~ MARRIED, ~~WIDOWED, DIVORCED,~~ (Specify)
8. DATE OF BIRTH 8-31-26
9. AGE last birthday 23 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer -
10b. KIND OF BUSINESS OR INDUSTRY General labor
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Unknown
14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Unknown (If yes, give war or dates of service)
16. SOCIAL SECURITY No.
17. INFORMANT AND ADDRESS Mother-939 Sommerset St., Balto., Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Acute Respiratory Failure	?
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Meningitis, Tubercular	
	(c) Valvular Heart Disease (Mitral)	

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14

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from August 4 1950, to August 8 1950, that I last saw the deceased alive on August 8, 1950, and that death occurred at 4:40 A. m., from the causes and on the date stated above.

SIGNATURE John A Clark (Degree or title) ADDRESS DATE SIGNED
John A. Clark, M. D., Physician in Charge, MHC Jessup, Md. 8/8/50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF Aug 10-50
NAME OF CEMETERY OR CREMATORY Mt Calvary SMITHFIELD
LOCATION (City, town, or county) (State) Anne Arundel Co Md

DATE REC'D BY LOCAL REG. 8-9-50
REGISTRAR'S SIGNATURE Clara Haslup
24. FUNERAL DIRECTOR Mrs R A Elliott ADDRESS
1129 N Caroline Balto
98899

RECEIVED
AUG 2? 1950
BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

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Reg. Dist. No. 21

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The correct age

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. is especially important. Physicians: please write the causes of death clearly and legibly.

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VS. A15

1. PLACE OF DEATH: COUNTY ANNE ARUNDEL MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN MARLEY PARK
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 425 OLD ANNAPOLIS RD.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND COUNTY A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN GLEN BURNIE RURAL
STREET ADDRESS (If rural, give location) 425 OLD ANNAPOLIS RD., MARLEY PARK.

3. NAME OF DECEASED (Type or Print): (First) DAVID. (Middle) (Last) BUELLIS

4. DATE OF DEATH: (Month) Aug (Day) 17 (Year) 1950

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) SINGLE

8. DATE OF BIRTH: Aug 17, 1950

9. AGE last birthday: 0 yrs. If under 1 year: Months 0 Days 0 If under 24 hrs.: Hours 0 Min. 15

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: WILLIAM BUELLIS

14. MOTHER'S MAIDEN NAME: ALBERTA LOUISE TYDINGS.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY No.: NONE

17. INFORMANT AND ADDRESS: WILLIAM BUELLIS, GLEN BURNIE MD.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

762.0 **Immediate cause** (a) ATELECTASIS — 15 min

161a **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug 17, 1950, to Aug 17, 1950, that I last saw the deceased alive on Aug 17, 1950, and that death occurred at 3:00 P m., from the causes and on the date stated above.

SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED

C. Milton Linthicum, M.D. Linthicum Heights, MD. 8/17/50

23. BURIAL, CREMATION REMOVAL (Specify) BURIAL | DATE THEREOF AUG 18, 1950 | NAME OF CEMETERY OR CREMATORY GLEN HAVEN | LOCATION (City, town, or county) GLEN BURNIE (State) MD

DATE REC'D BY LOCAL REG. 8/18/50 | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR Thomas W. Singleton | ADDRESS Glen Burnie Md

1-0-8-17-0-43-5-40-8

RECEIVED
AUG 21 1950
BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

07871

Reg. Dist. No.....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY Anna Arundel MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bay Side Beach; LENGTH OF STAY (in this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS Bay Side Beach Pasadena MD

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Anna Arundel COUNTY MD; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bay Side Beach Pasadena MD; STREET ADDRESS (If rural give location) Burgess Rd.

3. NAME OF DECEASED (Type or Print): (First) Ernest (Middle) (Last) Chevaux

4. DATE OF DEATH: (Month) Aug. (Day) 16 (Year) 1950

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: Oct 25-1895

9. AGE last birthday: 54 yrs. If under 1 year: Months Days; If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Engineer.

10b. KIND OF BUSINESS OR INDUSTRY: Pennsylvania R.R.

11. BIRTHPLACE (State or foreign country): Brooklyn N.Y.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Ernest F. Chevaux

14. MOTHER'S MAIDEN NAME: Emily Lagiarce

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): Yes

16. SOCIAL SECURITY NO.:

17. INFORMANT: Olga. Chevaux.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
199.2 Immediate cause	(a) Carcinomatosis	not known
55e Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Carcinoma etiology undetermined	10 months
	(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 15, 1950, to Aug. 16, 1950, that I last saw the deceased alive on Aug. 15, 1950, and that death occurred at 6:50 A.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Randall M. McLaughlin	M.D	Pasadena, Md.	Aug. 16, 1950

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	8-19-50	Holy Cross Cem	A A. Co.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
8/16/50	A. W. Hedrick	Bernard C. Hark	131 E West St

32247

M

I

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

07872

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Eastport
LENGTH OF STAY (in this place) 33 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS 205 Chesapeake Ave

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Eastport
STREET ADDRESS (If rural, give location) 205 Chesapeake Ave

3. NAME OF DECEASED (Type or Print) (First) David (Middle) Wardell (Last) Collison

4. DATE OF DEATH (Month) August (Day) 13 (Year) 1950

5. SEX M

6. COLOR OR RACE W

7. ~~SINGLE~~, MARRIED, ~~WIDOWED~~, ~~DIVORCED~~, (Specify)

8. DATE OF BIRTH 7/31/1873

9. AGE last birthday 77 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Watchman

10b. KIND OF BUSINESS OR INDUSTRY U.S. Government

11. BIRTHPLACE (State or foreign country) Oxford, Md

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME — Not Known

14. MOTHER'S MAIDEN NAME — Not Known

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Son Chas. F. Collison

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1 Immediate cause (a) Acute Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2nd attack

Antecedent cause(s)

94a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) — 1 one month ago

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION —

19b. MAJOR FINDINGS OF OPERATION —

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-13, 1950, to 8-13, 1950, that I last saw the deceased alive on —, 19—, and that death occurred at 6:00 A m., from the causes and on the date stated above.

SIGNATURE Francis I. Codd (Degree or title) M.D. ADDRESS DATE SIGNED 8-13-50

23. BURIAL, ~~CREMATION~~ ~~REMOVAL~~ (Specify) DATE 8/15/50 NAME OF CEMETERY OR CREMATORY Cedar Bluff LOCATION (City, town, or county) A.A. Co. (State) Md

DATE REC'D BY LOCAL REG. August 14, 1950 REGISTRAR'S SIGNATURE [signature] 24. FUNERAL DIRECTOR John M. Taylor & Son ADDRESS Annapolis, Md

602-97

RECEIVED
AUG 15 1950
BUREAU OF S

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

07873

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY: Anne Arundel — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Marley Park
LENGTH OF STAY (In this place): 5 months
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 9 Beach St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Illinois — COUNTY:
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: East St. Louis - (P.O. Box 141)
STREET ADDRESS (If rural, give location): 323 N. Rock Road (Last Known)

3. NAME OF DECEASED (Type or Print): (First) Arthur (Middle) (Last) Corbisez, Sr.

4. DATE OF DEATH: (Month) (Day) (Year) Aug. 18. 1950

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: 7/21/79

9. AGE last birthday: 71 yrs. — If under 1 year: Months — Days — If under 24 hrs.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired laborer

10b. KIND OF BUSINESS OR INDUSTRY: General labor

11. BIRTHPLACE (State or foreign country): Abscon, France.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Unknow

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 511-03-5172

17. INFORMANT: Sergeant A.A. Corbisez, (son). Marley Park Glen Burnie

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

903.0 Immediate cause (a) Cerebral hemorrhage, due to injury to head — Sudden

186a Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Fell on concrete pavement, on his head.

(c)

11. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. EXTERNAL CAUSE WAS PRIMARY X OR CONTRIBUTING ☐ CAUSE OF DEATH. — PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: Home — (CITY OR TOWN) (COUNTY) (STATE): Marley Park, Anne Arundel, Md.

TIME OF INJURY (Month) (Day) (Year) (Hour): 8/17/50 11.30 P.M. — INJURY OCCURRED While at work ☐ Not while at work X — HOW DID INJURY OCCUR?: Fell onto a concrete landing.

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry X thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident X, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE: [signature] M.D. — (Degree or title) ADDRESS: Asst. Medical Examiner, Glen Burnie, Md. — DATE SIGNED: 8/18/50

23. BURIAL, CREMATION, REMOVAL (Specify): BURIAL — DATE THEREOF: AUG. 22, 1950 — NAME OF CEMETERY OR CREMATORY: CEDAR HILL — LOCATION (City, town, or county) (State): BROOKLYN. (RURAL) MD

DATE REC'D BY LOCAL REG.: 8/21/50 — REGISTRAR'S SIGNATURE: [signature] — 24. FUNERAL DIRECTOR: Thomas W. Singleton — ADDRESS: Glen Burnie, Md

78699

VS: A15A

RECEIVED
AUG 22 1950
BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

07874

Reg. Dist. No.

1. PLACE OF DEATH- COUNTY: Anne Arundel MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED- STATE: Maryland COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Crownsville — LENGTH OF STAY (in this place): one year two months	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Pasadena
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Crownsville State Hospital	STREET ADDRESS (If rural, give location): Route 3

3. NAME OF DECEASED (Type or Print): (First) Lonnie (Middle) (Last) Coulter

4. DATE OF DEATH: (Month) 8/3/50 (Day) (Year) 19

5. SEX: male

6. COLOR OR RACE: colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married

8. DATE OF BIRTH: not known July 14, 1896

9. AGE last birthday: 54 yrs. If under 1 year: Months, Days. If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): longshoreman

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (State or foreign country): North Carolina

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: William Coulter

14. MOTHER'S MAIDEN NAME: Lizzie Ash

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)

16. SOCIAL SECURITY NO.: not known

17. INFORMANT AND ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) General Paresis	known since
Antecedent cause(s)		5/20/49
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c)	

025X

30b

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: none

19b. MAJOR FINDINGS OF OPERATION: none

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify): none

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): none (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour): none m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR? none

22. I hereby certify that I attended the deceased from 5/20/49, 19....., to 8/3/50, 19....., that I last saw the deceased alive on 8/3/50, 19....., and that death occurred at 7:06 A. m., from the causes and on the date stated above.

SIGNATURE: Jacob Morgenstern M.D. (Degree or title) ADDRESS: Crownsville State Hospital DATE SIGNED: 8/3/50

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE: Aug 4, 1950 — NAME OF CEMETERY OR CREMATORY: Newton — LOCATION (City, town, or county): Newton, North Carolina (State)

DATE REC'D BY LOCAL REG.: 8/4/50 — REGISTRAR'S SIGNATURE: A W Hedrick — 24. FUNERAL DIRECTOR: Mrs Katie A Williams — ADDRESS: 327 N Schroeder St

90651

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

07875

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A

1. PLACE OF DEATH: COUNTY a a — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis Rural
LENGTH OF STAY (In this place) 1 day
HOSPITAL OR INSTITUTION OR STREET ADDRESS Maureen Retreat Home

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Washington DC COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN
STREET ADDRESS (If rural give location) 207 Sheridan St N.E.

3. NAME OF DECEASED (Type or Print): (First) Wilson (Middle) L (Last) Cunningham

4. DATE OF DEATH: (Month) Aug. (Day) 26 (Year) 1950

5. SEX M

6. COLOR OR RACE W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH Nov 6 - 1875

9. AGE last birthday 74 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired U.S. Government

10b. KIND OF BUSINESS OR INDUSTRY Clerk

11. BIRTHPLACE (State or foreign country) Washington D.C.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME William L Cunningham

14. MOTHER'S MAIDEN NAME Susan Crowe

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No

16. SOCIAL SECURITY NO. None

17. INFORMANT Dorothy McC. Millican

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1 **Immediate cause** (a) Coronary Occlusion — Interval between onset and death: Sudden.

94a **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION —

19b. MAJOR FINDINGS OF OPERATION —

20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at work ☐ Not while at work ☐ — HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE Jerome A. Paulson MD (Degree or title) Assistant Medical Examiner ADDRESS Glen Burnie, Md. DATE SIGNED 8/26/50

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE THEREOF Aug 29/50 — NAME OF CEMETERY OR CREMATORY Fort Lincoln — LOCATION (City, town, or county) (State) Bladensburg Pr. Geo. Md

DATE REC'D BY LOCAL REG. Aug. 26, 1950 — REGISTRAR'S SIGNATURE — 24. FUNERAL DIRECTOR AND ADDRESS Frances J Collins Washington D.C.

26697

RECEIVED
AUG 29 1950
BUREAU OF S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

07876

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Eastport
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 408 Second

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Eastport
STREET ADDRESS (If rural, give location) 408 Second St.

3. NAME OF DECEASED (Type or Print) (First) Ruth (Middle) Ann (Last) Donaldson
4. DATE OF DEATH (Month) 8 (Day) 19 (Year) 1950

5. SEX F.
6. COLOR OR RACE W.
7. SINGLE, ~~MARRIED~~, ~~WIDOWED~~, ~~DIVORCED~~ (Specify)
8. DATE OF BIRTH 6-23-1946
9. AGE last birthday 4 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none
10b. KIND OF BUSINESS OR INDUSTRY none
11. BIRTHPLACE (State or foreign country) Annapolis Md
12. CITIZEN OF WHAT COUNTRY U.S.A.

13. FATHER'S NAME William F. Donaldson
14. MOTHER'S MAIDEN NAME Ruth P. Higgs

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY No.
17. INFORMANT AND ADDRESS Wm F. Donaldson Easport Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			INTERVAL BETWEEN ONSET AND DEATH
351 X	Immediate cause	(a) Terminal Bronchial Pneumonia	3 days
87e	Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Received Palsy (Congenital)	4 years
		(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11, 1946, to Aug 19, 1950, that I last saw the deceased alive on Aug 19, 1950, and that death occurred at 6 30/P m., from the causes and on the date stated above.

SIGNATURE Gene C Bosil (Degree or title) M. D. ADDRESS Annapolis Md DATE SIGNED 8-21-50

23. BURIAL, ~~CREMATION~~ ~~REMOVAL~~ (Specify)
DATE THEREOF 8/22/50
NAME OF CEMETERY OR CREMATORY Cedar Bluff
LOCATION (City, town, or county) Annapolis (State) Md.

DATE REC'D BY LOCAL REG. Aug. 21, 1950
REGISTRAR'S SIGNATURE [signature]
24. FUNERAL DIRECTOR John M. Taylor Son ADDRESS Annapolis Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A16

RECEIVED
AUG 23 1950
BUREAU V. S

Evidence for change of age shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

FILM No. G 128 SEP 15 1950

CERTIFICATE OF DEATH

117877

Reg. Dist. No. 28

1. PLACE OF DEATH: COUNTY Crownsville State Hospital; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Crownsville; LENGTH OF STAY (in this place) 3 mts; HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Washington; COUNTY Md; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural (Hagerstown, Md.; STREET ADDRESS (If rural, give location) Washington County

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Fred		Dozier	August	19	1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
male	negro	married	June 20 1890	60 (54?) yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Box maker

10b. KIND OF BUSINESS OR INDUSTRY: West. Md Railroad

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: unknown

14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY No. 705 10 6197

17. INFORMANT AND ADDRESS: Mrs. Ella Dozier(wife) 425 N. Jonathon St Hagerstown Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) General Paresis	Known to
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) General Paresis	us since
	(c)	May 20/50

025X
301

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from May 20, 19.50., to August 19 19.,50, that I last saw the deceased alive on August 19., 19.50., and that death occurred at 2:20 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Carl Marquette M.D

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
burial	8/23/50	Fairview Cem.	Fredic. Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS
Aug 19- 1950	M.E.	Wiliam H Downey, 291 Frederick St, Hagerstown, Maryland

49447

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
SEP 6 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

07878

Reg. Dist. No. 27

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. 415

1. PLACE OF DEATH: COUNTY: Anne Arundel; STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Ft. Geo G Meade, Md
LENGTH OF STAY (in this place): -
HOSPITAL OR INSTITUTION OR STREET ADDRESS: STATION HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Ohio; COUNTY: Jefferson
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Steubenville
STREET ADDRESS (If rural, give location): 412 Grant Street

3. NAME OF DECEASED (Type or Print): (First) WILLIAM (Middle) HENRY (Last) DRUMMOND

4. DATE OF DEATH: (Month) August (Day) 1 (Year) 1950

5. SEX: Male

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: 27 Sept 1920

9. AGE last birthday: 29 yrs. If under 1 year: Months. Days. If under 24 hrs: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Soldier

10b. KIND OF BUSINESS OR INDUSTRY: US Army

11. BIRTHPLACE (State or foreign country): North Carolina

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes
(If year, give war or dates of service): 1943 to date

16. SOCIAL SECURITY NO.: -

17. INFORMANT AND ADDRESS: Service Records US Army Ft Geo G Meade, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

981 X
166

Immediate cause (a) Wound, penetrating, gunshot, left anterior chest, left lobe of liver, peripancreatic tissue, retro peri-

Antecedent cause(s) (b) ---

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) Wound, gunshot, penetrating, left posterior chest, 9-10 vertebrae.

INTERVAL BETWEEN ONSET AND DEATH:

II. OTHER SIGNIFICANT CONDITIONS? Conditions contributing to the death but not related to the disease or condition causing death. Hemoperitoneum, massive.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes [X] No [ ]

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): Homicide

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: Civilian Dormitories

(CITY OR TOWN): Ft Geo G Meade

(COUNTY): Anne Arundel

(STATE): Md

TIME OF INJURY (Month) (Day) (Year) (Hour): Aug 1 50 0615 m.

INJURY OCCURRED While at Work [ ] Not While At work [X]

HOW DID INJURY OCCUR? Shot by civilian employee

22. I hereby certify that I attended the deceased from August 1, 1950, to ....., 19....., that I last saw the deceased alive on August 1, 1950, and that death occurred at 0615 m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Robert L Tornello M.D. ADDRESS: ROBERT L TORNELLO, M.D. DATE SIGNED:

23. BURIAL, CREMATION REMOVAL (Specify): Removal

DATE: 1 Aug 50

NAME OF CEMETERY OR CREMATORY:

LOCATION (City, town, or county) (State):

DATE REC'D BY LOCAL REG: 1 Aug 50

REGISTRAR'S SIGNATURE: E. K. BURNSIDE, CAPT., MSC

24. FUNERAL DIRECTOR: Charles R Law, Inc ADDRESS: Balto, Maryland

60896

RECEIVED
AUG 3 1950
BUREAU V. S

Evidence for change of age shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

07879

Reg. Dist. No. 21

FILM No. G 127 AUG 14 1950

1. PLACE OF DEATH: COUNTY Anne Arundel — STATE MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bay Ridge — LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION (Or STREET ADDRESS) 24 Upshur Road

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. — COUNTY aa.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bay Ridge
STREET ADDRESS (If rural, give location) 24 Upshur Road

3. NAME OF DECEASED (Type or Print): (First) Minnie (Middle) Kathryn (Last) Firehock

4. DATE OF DEATH: (Month) 8 (Day) 1 (Year) 1950

5. SEX: F — 6. COLOR OR RACE: W — 7. SINGLE, MARRIED, WIDOWED, ~~DIVORCED~~, (Specify) — 8. DATE OF BIRTH: Oct 29-1880 — 9. AGE: Last birthday 69 70 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife — 10b. KIND OF BUSINESS OR INDUSTRY: domestic — 11. BIRTHPLACE (State or foreign country): New York City — 12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: Unknown — 14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) — 16. SOCIAL SECURITY No. — 17. INFORMANT AND ADDRESS: Mrs Jos Hopkins Bay Ridge Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

420.0 **Immediate cause** (a) Coronary occlusion — 1 day

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b) auricular fibrillation — 2 days
932 (c) arteriosclerotic heart Disease 1 yr

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7-30, 1950, to 8-1, 1950, that I last saw the deceased alive on 8-1, 1950, and that death occurred at 12:30 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) — ADDRESS — DATE SIGNED
James R. Martin M.D. Annapolis, Md. 8-1-50

23. BURIAL, CREMATION, REMOVAL (Specify) — DATE THEREOF 8-1-50 — NAME OF CEMETERY OR CREMATORY — LOCATION (City, town, or county) Union City (State) N.J.

DATE REC'D BY LOCAL REG. Aug. 1, 1950 — REGISTRAR'S SIGNATURE — 24. FUNERAL DIRECTOR John M. Taylor Son — ADDRESS Annapolis Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
AUG 3 1950
BUREAU P. S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

07880 21
Reg. Dist. No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Anne A undel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Gambrills Rural
LENGTH OF STAY (in this place): MARYLAND
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Gambrills Post Office

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland
COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural Gambrills
STREET ADDRESS (If rural, give location): Gambrills Post Office

3. NAME OF DECEASED (Type or Print): (First) MABEL (Middle) E. (Last) FLEMING

4. DATE OF DEATH: (Month) Aug. (Day) 28, (Year) 1950

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: May 5, 1877

9. AGE last birthday: 73 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife

10b. KIND OF BUSINESS OR INDUSTRY: own

11. BIRTHPLACE (State or foreign country): Gambrills, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: (Unknown) Moque

14. MOTHER'S MAIDEN NAME: Catherine Joyce

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: none

17. INFORMANT AND ADDRESS: Mr. O. T. Brise Annapolis, Maryland

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Carcinoma Pancreas — Interval between onset and death: 4 months

157X

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b)
469
(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Cardio Vascular Disease — 1 Yr.

19a. DATE OF OPERATION: Aug 12-50

19b. MAJOR FINDINGS OF OPERATION: Carcinoma Pancreas.

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug 15, 1950, to Aug 28, 1950, that I last saw the deceased alive on Aug 26-50, and that death occurred at 6.25 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Lewis Lapsley M.D. Odenton Md Aug 29-50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF: Aug. 30, 1950

NAME OF CEMETERY OR CREMATORY: Baldwin Memorial

LOCATION (City, town, or county) (State): Millersville, Maryland

DATE REC'D BY LOCAL REG.: 8-29-50

REGISTRAR'S SIGNATURE: M.E. Dyer

24. FUNERAL DIRECTOR ADDRESS: B.L. Hopping and Son Annapolis, Md.

RECEIVED
SEP 6 1950
BUREAU OF

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

I

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 07881 21

1. PLACE OF DEATH: COUNTY ANNE ARUNDEL MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN GAMBRILLS (RURAL) LENGTH OF STAY (in this place) 8 YRS.
HOSPITAL OR INSTITUTION OR STREET ADDRESS CRAIN HWY 1/4 MI. STH. ANDERSON'S CORNER

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND COUNTY A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN GAMBRILLS (RURAL)
STREET ADDRESS (If rural, give location) CRAIN HWY 1/4 MI. STH. ANDERSON'S CORNER

3. NAME OF DECEASED (Type or Print) (First) MARIAN (Middle) E. (Last) GATTON

4. DATE OF DEATH (Month) AUG. (Day) 16 (Year) 1950

5. SEX FEMALE

6. COLOR OR RACE WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED

8. DATE OF BIRTH JULY 4, 1909

9. AGE last birthday 31 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWORK

10b. KIND OF BUSINESS OR INDUSTRY OWN HOME.

11. BIRTHPLACE (State or foreign country) OWINGS, (MT. HARMONY) CALVERT Co.

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME JAMES S. CHATTERTON

14. MOTHER'S MAIDEN NAME ROSA CHANEY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)

16. SOCIAL SECURITY No. 577-28-4588

17. INFORMANT AND ADDRESS Mrs LULA DONN, 504, 68TH. ST. SEAT PLEASANT MD

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

171X Immediate cause (a) Carcinoma of the Cervix — INTERVAL BETWEEN ONSET AND DEATH: 6 months

48a Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. —

19a. DATE OF OPERATION 4/50

19b. MAJOR FINDINGS OF OPERATION Carcinoma of the cervix.

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify) NO

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) NO m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from —, 19....., to —, 19....., that I last saw the deceased alive on —, 19....., and that death occurred at 1.20 A.m., from the causes and on the date stated above.

SIGNATURE Gustave H. Faubert MD (Degree or title) ADDRESS Glen Burnie, Md. DATE SIGNED 8/17/50

23. BURIAL, CREMATION REMOVAL (Specify) BURIAL

DATE THEREOF AUG. 19, 1950

NAME OF CEMETERY OR CREMATORY MT HARMONY

LOCATION (City, town, or county) OWINGS, (State) MD

DATE REC'D BY LOCAL REG. 8/17/50

REGISTRAR'S SIGNATURE L. J. DeAlba

24. FUNERAL DIRECTOR Thomas W. Singleton ADDRESS Glen Burnie, Md

RECEIVED
AUG 21 1950
BUREAU T. S

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS. A15 T

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 07882 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hanover
LENGTH OF STAY (in this place) 10 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS Ridge Rd.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hanover
STREET ADDRESS (If rural, give location) Ridge Rd

3. NAME OF DECEASED (Type or Print) (First) George (Middle) Herbert (Last) Geyer

4. DATE OF DEATH (Month) Aug (Day) 31 (Year) 1950

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married
8. DATE OF BIRTH Nov 1 1989
9. AGE last birthday 60 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Contractor & Builder
10b. KIND OF BUSINESS OR INDUSTRY Building
11. BIRTHPLACE (State or foreign country) Baltimore City
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Samuel Geyer
14. MOTHER'S MAIDEN NAME Mary Cross

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no
16. SOCIAL SECURITY No.
17. INFORMANT AND ADDRESS Mrs Marguerite W. Geyer Hanover Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a)	Acute Coronary occlusion recurrent	2 hrs
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	Chr. Myocarditis	4 yrs
	(c)	General arteriosclerosis	5 yrs

420.1
93d

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION —
19b. MAJOR FINDINGS OF OPERATION —
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct, 1946, to Aug 31, 1950, that I last saw the deceased alive on Aug 31, 1950, and that death occurred at 8:05 a.m., from the causes and on the date stated above.

SIGNATURE Dr B B Brumbaugh (Degree or title) ADDRESS 5609 Main St Elkridge 27 Md DATE SIGNED 8/31/50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF Sept 4, 1950
NAME OF CEMETERY OR CREMATORY Laudon Park
LOCATION (City, town, or county) (State) Baltimore, Md.

DATE REC'D BY LOCAL REG. 9/2/50
REGISTRAR'S SIGNATURE L. J. DeAlba
24. FUNERAL DIRECTOR R V Singleton ADDRESS Glen Burnie, Md.

15649

RECEIVED
SEP 6 1960
BUREAU U. S.

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 07883

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville
LENGTH OF STAY (in this place) 4 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Balt.City
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore
STREET ADDRESS (If rural give location) ~~not known~~ 1327 N. Caroline SX

3. NAME OF DECEASED (Type or Print) (First) Theodore (Middle) (Last) Gilchrist

4. DATE OF DEATH (Month) (Day) (Year) 8/14/50 19

5. SEX male
6. COLOR OR RACE colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) not known Married
8. DATE OF BIRTH not known 1-7-1908
9. AGE last birthday not known 42 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer ~~not known~~
10b. KIND OF BUSINESS OR INDUSTRY not known
11. BIRTHPLACE (State or foreign country) ~~not known~~ S.C
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME ~~not known~~ Hermon Gilchrist
14. MOTHER'S MAIDEN NAME ~~not known~~ NOT known

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) not known
16. SOCIAL SECURITY NO. —
17. INFORMANT Hazel Gilchrist Hospital Records 625 N. Bethel SX

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

353.2 Immediate cause (a) Cerebral Hemorrhage

83a Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Status Epilepticus (c)

INTERVAL BETWEEN ONSET AND DEATH: known since 8/11/50; 8 hours duration

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION none
19b. MAJOR FINDINGS OF OPERATION none
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) none
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none (CITY OR TOWN) none (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) none m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR? none

22. I hereby certify that I attended the deceased from 8/10/50, 19....., to 8/14/50, 19....., that I last saw the deceased alive on 8/14/50, 19....., and that death occurred at 4:45 A.M. m., from the causes and on the date stated above.

SIGNATURE Jacob Morgenstern M.D. (Degree or title) ADDRESS Crownsville, Md. DATE SIGNED 8/15/50

23. BURIAL, CREMATION REMOVAL (Specify) Shipped
DATE THEREOF 8-17/50
NAME OF CEMETERY OR CREMATORY Dillon S.C.
LOCATION (City, town, or county) S.C (State) S.C

DATE REC'D BY LOCAL REG. 8/17/50
REGISTRAR'S SIGNATURE H.W. Hedrick
24. FUNERAL DIRECTOR Rayner Sanders ADDRESS 1412 Preston St. Baltimore

98819

Evidence for change in #8 as shown on:

07884

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

FILM No. G 127 AUG 31 1950

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH — COUNTY: Anne Arundel — MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Maryland — COUNTY: Baltimore City
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Crownsville — LENGTH OF STAY (in this place): 1 yr. 3 mos.	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore City
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Crownsville State Hospital	STREET ADDRESS (If rural, give location): 1613 E. Monument Street

3. NAME OF DECEASED (Type or Print)	(First) Modie	(Middle)	(Last) Green	4. DATE OF DEATH (Month) 8 (Day) 19 (Year) 1950
5. SEX: Female	6. COLOR OR RACE: Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH: ? ~~1871~~ 1879	9. AGE last birthday: 71 yrs. — If under 1 year: Months — Days — If under 24 hrs.: Hours — Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —	10b. KIND OF BUSINESS OR INDUSTRY: —	11. BIRTHPLACE (State or foreign country): South Carolina	12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME: Ben Roberts		14. MOTHER'S MAIDEN NAME: Bettie ?		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) — (If yes, give war or dates of service) —	16. SOCIAL SECURITY No.: —	17. INFORMANT AND ADDRESS: Hospital Records		

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			INTERVAL BETWEEN ONSET AND DEATH
422.1	Immediate cause	(a) Chronic myocarditis	Known to us since 5/13/49
93d	Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) General Arteriosclerosis	Known to us since 5/13/49
		(c) Psychosis with Cerebral Arteriosclerosis	Known to us sin 5/13/49

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: —	19b. MAJOR FINDINGS OF OPERATION: —	20. AUTOPSY? Yes ☐ No ☒
21. ACCIDENT SUICIDE HOMICIDE (Specify): —	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): —	(CITY OR TOWN) (COUNTY) (STATE): —
TIME OF INJURY (Month) (Day) (Year) (Hour): — m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from 5/13, 1949, to 8/19, 1950, that I last saw the deceased alive on 8/19, 1950 and that death occurred at 1:35 p.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Jacob Morgenstern	M.D.	Crownsville State Hospital	8/19/50

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Aug. 26-1950	Mt Calvary Cemetery	A. A. Co. Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
8/23/50	A. W. Heduck JT	Robert E. Williams	1515 McElderry St

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

I

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07885

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Riviera Beach
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 months

Hospital, institution, or street address where death occurred:
Meadow & Bay Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: A. A.

City or town: Riviera Beach
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Meadow & Bay Road
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Jefferson Lafayette Hagler

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Daisy Lee Hagler

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct - 1 - 1861

8. AGE:

Years	Months	Days	If less than one day
88	10	21	..... hrs. ..... min.

9. Birthplace: Montgomery Alabama
(Town, county, and state)

10. Usual occupation: Retired - Merchant

11. Industry or business: General Store

FATHER
12. Name: Isaac N. Hagler
13. Birthplace: Unknown

MOTHER
14. Maiden name: Elizabeth ?
15. Birthplace: Unknown

16. Informant: Emile W. Teede

Address: Meadow & Bay Road - Riviera Beach

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 24 1950 (month) (day) (year)

Cemetery or crematory: Western

Location: Baltimore City

18. Funeral director: Mr. & Mrs. John W. Teufel & Son

Address: 5311 Edmondson Ave.

19. 8/23 1950 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 22 1950, at 5:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 - 1950, to Aug 22 - 1950

and that I last saw him alive on Aug 21 1950

Immediate cause of death	DURATION
Hypostatic Pneumonia	4 days
Due to: Gradual unprovoked weakness	
Due to: General Debility	
Other conditions: 422.2	
93.2	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Thos. H. Phillips M. D. or other

Address: 3307 Edmondson Ave. Date signed: 8-22-50

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

07886

Reg. Dist. No. 28

1. PLACE OF DEATH
COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Crownsville
LENGTH OF STAY (in this place): 6 months
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Pr. George's
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Upper Marlboro, Maryland
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): (First) CHARLES (Middle) (Last) HAMILTON

4. DATE OF DEATH: (Month) Aug. (Day) 23, (Year) 1950

5. SEX: male

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

8. DATE OF BIRTH: 7/4/06

9. AGE last birthday: 44 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: unk.

11. BIRTHPLACE (State or foreign country): Upper Marlboro, Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Tom Hamilton

14. MOTHER'S MAIDEN NAME: Agnes Camper

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.:

17. INFORMANT AND ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) General Paresis	2/23/50
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	to
	(c)	8/23/50

025X
308

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. none

19a. DATE OF OPERATION: none

19b. MAJOR FINDINGS OF OPERATION: none

20. AUTOPSY? Yes ☑ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): none

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: none

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour): none m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb. 23, 1950, to Aug. 23, 1950, that I last saw the deceased alive on Aug. 23, 1950, and that death occurred at 3:00 p.m., from the causes and on the date stated above.

SIGNATURE: [signature] (Degree or title) M.D. ADDRESS: DATE SIGNED:

23. BURIAL, ~~CREMATION~~ REMOVAL (Specify) | DATE THEREOF: Aug. 26, 1950 | NAME OF CEMETERY OR CREMATORY: Crownsville | LOCATION (City, town, or county) (State): Crownsville State Hospital

DATE REC'D BY LOCAL REG.: Aug. 25, 1950 | REGISTRAR'S SIGNATURE: [signature]

24. FUNERAL DIRECTOR: Crownsville State Hospital, Crownsville, Md. ADDRESS:

98699

RECEIVED
SEP 6 1950
BUREAU V. S

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS-A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

07887

CERTIFICATE OF DEATH

Reg. Dist. No. 23

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Glen Burnie
LENGTH OF STAY (in this place) 8 MONTHS
HOSPITAL OR INSTITUTION OR STREET ADDRESS 20 Crain Highway N.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Tenn. COUNTY Anderson
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Lake City
STREET ADDRESS (If rural give location) rural route #1 ✓

3. NAME OF DECEASED (Type or Print) (First) EDWARD (Middle) MARSHAL (Last) HARRIS
4. DATE OF DEATH (Month) August (Day) 1 (Year) 1950
5. SEX male.
6. COLOR OR RACE W
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)
8. DATE OF BIRTH Sept 4, 1870
9. AGE last birthday 79 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) miner
10b. KIND OF BUSINESS OR INDUSTRY COAL MINE
11. BIRTHPLACE (State or foreign country) Tenn.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME John Harris
14. MOTHER'S MAIDEN NAME Sally Bibbs
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no. (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. none.
17. INFORMANT Ella Harris - wife LAKE CITY TENN.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
422.1 Immediate cause	(a) Cardiac Decompensation	6 months.
93d Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Arteriosclerotic Cardio Vascular Disease	
	(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Asthma

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12/10, 1950, to 8/1, 1950, that I last saw the deceased alive on 8/1, 1950, and that death occurred at 3:45 P.m., from the causes and on the date stated above.

SIGNATURE Bobby L. Jones (Degree or title) M.D. ADDRESS Glen Burnie, Md. DATE SIGNED 8/1/50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF 8/4/50
NAME OF CEMETERY OR CREMATORY Pine Hill Cemetery
LOCATION (City, town, or county) Lake City, (State) Tennessee
DATE REC'D BY LOCAL REG. 8/2/50
REGISTRAR'S SIGNATURE L. J. Dr Alba
24. FUNERAL DIRECTOR R. P. Singleton, ADDRESS Glen Burnie, Md.

454V2

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AUG 3 1950
BUREAU U. S.

MARYLAND STATE DEPARTMENT OF HEALTH

07888

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY Annapolis AA — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN — LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS (If rural, give location) 43 Washington

3. NAME OF DECEASED (Type or Print): (First) John (Middle) A. (Last) Jacobs
4. DATE OF DEATH: (Month) 8 (Day) 9 (Year) 1950
5. SEX: M
6. COLOR OR RACE: Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)
8. DATE OF BIRTH: 4-11-1887
9. AGE last birthday: 63 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Truck Driver
10b. KIND OF BUSINESS OR INDUSTRY: Gas & Coal
11. BIRTHPLACE (State or foreign country): Annapolis, AA Md.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Nicholas Jacobs
14. MOTHER'S MAIDEN NAME: Henretta Harris
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: 215-05-0784
17. INFORMANT: Vernard Jacobs

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

331X — Immediate cause (a) Cerebral Hemorrhage — 14 days

83a — Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Arterio - Selerotic Hypertension — 1 year

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None

19a. DATE OF OPERATION — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 26, 1950, to August 9, 1950, that I last saw the deceased alive on Aug 9, 1950, and that death occurred at 11:30 m., from the causes and on the date stated above.

SIGNATURE — (Degree or title) — ADDRESS — DATE SIGNED

L. P. Rulwar Dr. — M.D — 110 - Clay St Annapolis, Md — 8/10/50

23. BURIAL, CREMATION, REMOVAL (Specify) — DATE THEREOF 8-12-50 — NAME OF CEMETERY OR CREMATORY — LOCATION (City, town, or county) — (State)

Brewer Hill Cemetery — Annapolis AA — Md.

DATE REC'D BY LOCAL REG. August 12, 1950 — REGISTRAR'S SIGNATURE — 24. FUNERAL DIRECTOR — ADDRESS

William Reese — 108 Washington St. Annapolis, Maryla

42077

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AUG 15 1950
BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

07889

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (In this place) D.O.A.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Anne Arundel Gen. Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Davidsonville
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print): (First) EMORY (Middle) (Last) JOHNSON
4. DATE OF DEATH: (Month) Aug. (Day) 6 (Year) 1950

5. SEX: Male
6. COLOR OR RACE: Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married
8. DATE OF BIRTH: 1895
9. AGE last birthday: 55 yrs. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: Farm
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Ben Johnson
14. MOTHER'S MAIDEN NAME: Harriet Johnson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: no.
17. INFORMANT: Daniel Johnson (wife)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
4143 Immediate cause	(a) Cardio-vascular hypertensive disease	unknown
9382 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Arterio-sclerosis (General)	unknown
	(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☑

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
John N. LaFey, M.D., Deputy Medical Examiner Annapolis, Md 8-6-50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF: Aug. 10, 1950
NAME OF CEMETERY OR CREMATORY: Carroll's Chapel
LOCATION (City, town, or county): Mitchelville
(State): Md

DATE REC'D BY LOCAL REG.: Aug. 7, 1950
REGISTRAR'S SIGNATURE: [illegible]
24. FUNERAL DIRECTOR: J. B. Johnson
ADDRESS: Annapolis

86600

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
AUG 9 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

07890

CERTIFICATE OF DEATH

Reg. Dist. No.....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH
COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Greenhaven
LENGTH OF STAY (in this place): MARYLAND
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 4th Street

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland
COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Greenhaven
STREET ADDRESS (If rural give location): 4th Street

3. NAME OF DECEASED (Type or Print): (First) MARIA (Middle) (Last) JOHNSON

4. DATE OF DEATH: (Month) Aug. (Day) 26, (Year) 1950

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow

8. DATE OF BIRTH: May 29, 1862

9. AGE last birthday: 88 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: At home

11. BIRTHPLACE (State or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Hames Stafford

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give wer or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Curtis Bay
Mrs Catherine Schneider, 1600 Cereal St.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

450,0
97

Immediate cause (a) Heart failure — 2 days.

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b) old age — years
(c) Arteriosclerosis — Unknown

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. none.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, ferm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 15, 19 50, to Aug. 26, 19 50, that I last saw the deceased alive on Aug. 26, 19 50, and that death occurred at 12:15 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED
Randall M. McLaughlin, M.D. | Pasadena, Md. | Aug. 26, 1950

23. BURIAL, CREMATION OR REMOVAL (Specify): Burial | DATE THEREOF: 8/30/50 | NAME OF CEMETERY OR CREMATORY: Cedar Hill | LOCATION (City, town, or county): Anne Arundel County (State): Md.

DATE REC'D BY LOCAL REG.: 8/28/50 | REGISTRAR'S SIGNATURE: Asa. Hedrick | 24. FUNERAL DIRECTOR: Wm. Cook Inc | ADDRESS: 1217 E. Lombard St

VS-A15

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

I

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

07891

CERTIFICATE OF DEATH

Reg. Dist. No. 25

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Severna Park
LENGTH OF STAY (in this place) One year
HOSPITAL OR INSTITUTION OR STREET ADDRESS Cedar Crest Nursing Home

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY ~~Anne Arundel~~
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN ~~Severna Park~~ Baltimore
STREET ADDRESS (If rural, give location) ~~Cedar Crest Nursing Home~~

3. NAME OF DECEASED (Type or Print) (First) William (Middle) (Last) Johnson

4. DATE OF DEATH (Month) Aug. (Day) 15-1950 (Year) 19

5. SEX Male

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single

8. DATE OF BIRTH 10/7/71

9. AGE last birthday 78 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Conducted tours to Europe

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Ohio

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Not Known

14. MOTHER'S MAIDEN NAME Not Known

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT AND ADDRESS Cedar Crest Nursing Home Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			INTERVAL BETWEEN ONSET AND DEATH
420.1	Immediate cause	(a) Coronary Occlusion	10 days
94a	Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) General vascular arterio-sclerotic ~~condition~~ disease	?
		(c) General Asthenia	?

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Anemia ?

19a. DATE OF OPERATION None

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) None

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct., 1949, to Aug. 14, 1950, that I last saw the deceased alive on 8/12/50, 19....., and that death occurred at 11.A.M. m., from the causes and on the date stated above.

SIGNATURE Gustave H. Pauber (Degree or title) ADDRESS Glen Burnie, Md. DATE SIGNED 8/15/50

23. BURIAL, CREMATION REMOVAL (Specify) DATE THEREOF August 18, 1950 NAME OF CEMETERY OR CREMATORY Glen Haven LOCATION (City, town, or county) Glenburnie Md. (State)

DATE REC'D BY LOCAL REG. Aug 17, 1950 REGISTRAR'S SIGNATURE Ida M. Whitson

24. FUNERAL DIRECTOR James L. McCully ADDRESS 130 E. Fort Ave

156 53

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AUG 22 1950
BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH

07892

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis — LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS A. A. General Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md — COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS (If rural, give location) Paca

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Leon	Phillip	Jones.	8	26	1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months.	Days	If under 24 hrs.: Hours	Min.
M	C	S.	Aug 24 1950	91 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Annapolis Md	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Leon Jones.	Edyth Harris

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
		Leon Jones

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) acute hemorrhagic disease. —

771.0 Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

161.0 (b) ? Septicemia —

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. CONVULSIONS

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☑ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF INJURY office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
			m.		

22. I hereby certify that I attended the deceased from 8-26, 1950, to 8-26, 1950, that I last saw the deceased alive on 8-26, 1950, and that death occurred at 6 50 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
Elizabeth Peardy Trentt M.D.	240 Prince George	8-27-50.

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Aug 29 1950	Brewer Hill	Annapolis, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Aug. 29, 1950	[signature]	J. B. Thomas	Annapolis, Md.

4-0-8-24-0-7-J-40-4

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AUG 29 1950
BUREAU V. S

07893

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Anne Arundel General Hosptial

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural
STREET ADDRESS (If rural, give location): Millersville, Maryland

3. NAME OF DECEASED (Type or Print): (First) RAYMOND (Middle) KOSTKOWSKI (Last) JR.

4. DATE OF DEATH: (Month) August (Day) 1 (Year) 1950

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: May 18, 1950

9. AGE last birthday: 0 yrs. — If under 1 year: Months 2, Days 13 — If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (State or foreign country): Annapolis, Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Raymond Kostkowski Sr.

14. MOTHER'S MAIDEN NAME: Greatude Norris

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): no — (If yes, give war or dates of service): none

16. SOCIAL SECURITY No.: none

17. INFORMANT AND ADDRESS: Mr. Raymond Kostkowski Sr. Millersville, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

754.4 **Immediate cause** (a) Congenital Heart Disease — 2 hrs 13 days

157e **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Prematurity (7 mos. pregnancy)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.):

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour): m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 18, 1950, to Aug 1, 1950, that I last saw the deceased alive on Aug. 1, 1950, and that death occurred at 11 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title): John M. Claffy M.D., Deputy Medical Examiner — ADDRESS: Annapolis, Md. — DATE SIGNED: 8-2-50.

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: August 3, 50 — NAME OF CEMETERY OR CREMATORY: Our Lady of the Fields — LOCATION (City, town, or county) (State): Millersville, Maryland

DATE REC'D BY LOCAL REG.: Aug. 2, 1950 — REGISTRAR'S SIGNATURE:

24. FUNERAL DIRECTOR — ADDRESS: B.L. Hopping and Son Annapolis, Md.

2-0-5-18-3 30-6-34-2

RECEIVED
AUG 3 1960
BUREAU F. S

07894

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY ANNE ARUNDEL MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN ANNAPOLIS
LENGTH OF STAY (in this place) 18 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS ANNE ARUNDEL GENERAL HOSP.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN GLEN BURNIE
STREET ADDRESS (If rural, give location) 310 FIFTH AVE., S.E.

3. NAME OF DECEASED (Type or Print) (First) JOHN (Middle) H. (Last) KLOHR
4. DATE OF DEATH (Month) AUG (Day) 18 (Year) 1950

5. SEX MALE
6. COLOR OR RACE WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) WIDOWER
8. DATE OF BIRTH APRIL 2, 1882
9. AGE last birthday 68 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK (RETIRED)
10b. KIND OF BUSINESS OR INDUSTRY FEED STORE
11. BIRTHPLACE (State or foreign country) BALTIMORE COUNTY
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME G. HARMAN KLOHR
14. MOTHER'S MAIDEN NAME BARBARA BAKER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. UNKNOWN
17. INFORMANT AND ADDRESS IRVIN T. KLOHR, 310-5TH AVE. S.E. GLEN BURNIE MD

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cirrhosis of liver

153X Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Carcinoma of Colon

46e (c) Myocarditis

INTERVAL BETWEEN ONSET AND DEATH: 2 yrs

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 8-7-50
19b. MAJOR FINDINGS OF OPERATION Carcinoma colon - cirrhosis liver
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7-31, 1950 to 8-18, 1950 that I last saw the deceased alive on 8-17, 1950, and that death occurred at ..... m., from the causes and on the date stated above.

SIGNATURE Charles R. MacDonald (Degree or title) ADDRESS Glen Burnie, Md. DATE SIGNED 8-18-50

23. BURIAL, CREMATION REMOVAL (Specify) BURIAL
DATE THEREOF AUG 21, 1950
NAME OF CEMETERY OR CREMATORY GLEN HAVEN
LOCATION (City, town, or county) GLEN BURNIE (State) MD.

DATE REC'D BY LOCAL REG. 8/21/50
REGISTRAR'S SIGNATURE [signature] Dr. French.
24. FUNERAL DIRECTOR Thomas W. Dougherty ADDRESS Glen Burnie Md

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VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
AUG 23 1950
BUREAU V. S

07895

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Anne Arundle
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis — LENGTH OF STAY (in this place) 45 yrs	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis,
HOSPITAL OR INSTITUTION OR STREET ADDRESS 17 Cornhill st	STREET ADDRESS (If rural, give location) 17 Cornhill Street

3. NAME OF DECEASED (Type or Print) (First) LEE (Middle) (Last) LAMB			4. DATE OF DEATH (Month) Aug. (Day) 5, (Year) 1950		
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH Oct. 28, 1904	9. AGE last birthday 45 yrs.	If under 1 year Months 9 Days 7 — If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffor	10b. KIND OF BUSINESS OR INDUSTRY Taxicab Company		11. BIRTHPLACE (State or foreign country) Annapolis, Maryland		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME William Lamb			14. MOTHER'S MAIDEN NAME Carrie Burke		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service) None		16. SOCIAL SECURITY NO. N	17. INFORMANT AND ADDRESS Mr. Olie Lamb 17 Cornhill St. Annapoli		

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Pulmonary Tuberculosis	Several years
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c)	

002 x
13 b

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)	
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from June, 1949, to Aug 5, 1950, that I last saw the deceased alive on Aug 1, 1950, and that death occurred at 4 A m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
George C. Basil	M. D.	Humphrey Md	8-6-50

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Aug 9, 1950	Cedar Bluff Cemetery	Annapolis, Maryland

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Aug. 7, 1950	[signature]	Ben L. Hopping and Son	Annapolis, Md.

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VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
AUG 9 1950
BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

07896

CERTIFICATE OF DEATH

Reg. Dist. No. 27

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY Anne Arundel; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Fort George G Meade; LENGTH OF STAY (in this place) 14 Hours; HOSPITAL OR INSTITUTION OR STREET ADDRESS U. S. Army Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE; COUNTY Q. A.; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Ft. Meade; STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) (Middle) LORENZ (Last)

4. DATE OF DEATH: August 21 1950

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): –

8. DATE OF BIRTH: 21 August 50

9. AGE last birthday: yrs. If under 1 year: Months. Days. If under 24 hrs: Hours 14 Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): –

10b. KIND OF BUSINESS OR INDUSTRY: –

11. BIRTHPLACE (State or foreign country): Fort George G Meade

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Melvin George Lorenz

14. MOTHER'S MAIDEN NAME: Adlegunde Marie Neuneyer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): – (If year, give war or dates of service): –

16. SOCIAL SECURITY NO.: –

17. INFORMANT AND ADDRESS: SFC Melvin G Lorenz, Fort Geo G Meade, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

762.0 Immediate cause (a) ASPHYXIA NEONATORUM — Interval between onset and death: 14 Hours

Antecedent cause(s)

161.0 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 21 August 1950 to 21 Aug 1950, that I last saw the deceased alive on 21 August 1950, and that death occurred at 1400 P m., from the causes and on the date stated above.

SIGNATURE Stanley L Blumenthal M.D. (Degree or title) ADDRESS

STANLEY L. BLUMENTHAL M. D. DATE SIGNED 21 Aug 50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE: 22 August 50

NAME OF CEMETERY OR CREMATORY: Post Cemetery

LOCATION (City, town, or county) (State): Fort George G Meade, Maryland

DATE REC'D BY LOCAL REG.: 23 August 50

REGISTRAR'S SIGNATURE: E. K. BURNSIDE CAPT., MSC

24. FUNERAL DIRECTOR: James F Hayes Capt., Chaplain Corps USA ADDRESS

2-0-8-21-0-28-3-36-5

RECEIVED
AUG 25 1950
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

07897

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel Co. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Oyster Bay
LENGTH OF STAY (In this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE D. C. COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Washington
STREET ADDRESS (If rural give location) 534 Columbia Road N. W.

3. NAME OF DECEASED (Type or Print) (First) DON (Middle) ARION (Last) LUCAS.
4. DATE OF DEATH (Month) 8 (Day) 28 (Year) 1950

5. SEX MALE.
6. COLOR OR RACE C.
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single.
8. DATE OF BIRTH Aug. 29 1939
9. AGE last birthday 11 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Boy
10b. KIND OF BUSINESS OR INDUSTRY none
11. BIRTHPLACE (State or foreign country) Washington, D.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Robert Lucas
14. MOTHER'S MAIDEN NAME Mary Payne

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Mary Payne Lucas

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

929.8 Immediate cause (a) Drowning.

183 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) Oyster Bay (COUNTY) A.A. (STATE) Md.
TIME OF INJURY (Month) (Day) (Year) (Hour) Aug 28, 1950 3:15 p.m.
INJURY OCCURRED While at work ☐ Not while at work ☒
HOW DID INJURY OCCUR? Drowning

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE E. Kim Ladd (Degree or title) M.S. ADDRESS Easport, Md DATE SIGNED 8/28/50.

23. BURIAL, CREMATION REMOVAL (Specify) Removal
DATE THEREOF Aug. 29, 50
NAME OF CEMETERY OR CREMATORY
LOCATION (City, town, or county) Washington (State) D.C.

DATE REC'D BY LOCAL REG. Aug. 29, 1950
REGISTRAR'S SIGNATURE [signature]
24. FUNERAL DIRECTOR J. B. Johnson ADDRESS Annapolis, Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
AUG 29 1950
BUREAU OF S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

07898

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH — COUNTY: Anne Arundel — MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Severn
LENGTH OF STAY (in this place): 20 year
HOSPITAL OR INSTITUTION OR STREET ADDRESS: New Cut Road

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE — COUNTY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Same
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): (First) Ernest (Middle) William (Last) Luedke

4. DATE OF DEATH: (Month) Aug. (Day) 29 (Year) 1950

5. SEX: Male
6. COLOR OR RACE: White
7. ~~SINGLE~~, MARRIED, ~~WIDOWED~~, ~~DIVORCED~~, (Specify): Married
8. DATE OF BIRTH: 8/28/87
9. AGE last birthday: 63 yrs. — If under 1 year: Months / Days — If under 24 hrs: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cabinet Maker
10b. KIND OF BUSINESS OR INDUSTRY: Retired
11. BIRTHPLACE (State or foreign country): Germany - Europe
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles Luedke
14. MOTHER'S MAIDEN NAME: Tillie Redding

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If year, give war or dates of service): 1918
16. SOCIAL SECURITY NO.: 220-09-5552
17. INFORMANT AND ADDRESS: Mrs. Mathilda Luedke (wife)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

570.5 Immediate cause (a) Gastro Intestinal Occlusion — 6 weeks

122 b Antecedent cause(s) (b) Malnutrition — 6 months

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)

II. OTHER SIGNIFICANT CONDITIONS — Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: —
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify): —
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 1949, to Aug 28, 1950, that I last saw the deceased alive on 8/28, 1950, and that death occurred at 5.25 P. m., from the causes and on the date stated above.

SIGNATURE: Gustave H. Pauker, M.D. (Degree or title) — ADDRESS: Glen Burnie, Md — DATE SIGNED: 8/29/50

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE: 8/1/50 — NAME OF CEMETERY OR CREMATORY: Woodlawn — LOCATION (City, town, or county): Woodlawn (State): Md

DATE REC'D BY LOCAL REG.: 8/31/50 — REGISTRAR'S SIGNATURE: [signature]

24. FUNERAL DIRECTOR: [illegible] Cook Inc 1214 St Paul St — ADDRESS:

496

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

07899

CERTIFICATE OF DEATH

Reg. Dist. No.....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY Anne Arundel; MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Crownsville; LENGTH OF STAY (in this place) 1½ months; HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Baltimore; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN R. F. D. #1 Phoenix; STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) Alverta; (Middle); (Last) Parker

4. DATE OF DEATH: (Month) 8; (Day) 17; (Year) 1950

5. SEX: Female

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow

8. DATE OF BIRTH: 8/17/69

9. AGE last birthday: 81 yrs. If under 1 year: Months; Days. If under 24 hrs.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY - - - -

11. BIRTHPLACE (State or foreign country): - Maryland

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Charles Edwards

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. - - - - - - - - -

17. INFORMANT AND ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

422.2 Immediate cause (a) Chronic myocarditis — Known to us since adm. 7/8/50

93d Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Senile Psychosis

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION - - - - - - - - 19b. MAJOR FINDINGS OF OPERATION - - - - - - - - 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) - - - - - - PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY - - - (CITY OR TOWN) - - - (COUNTY) - - - (STATE) - - -

TIME OF INJURY (Month) (Day) (Year) (Hour) - - - - - - - -

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

07900

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Crownsville
LENGTH OF STAY (in this place) 2 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Baltimore City
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore City
STREET ADDRESS (If rural, give location) Unknown

3. NAME OF DECEASED (Type or Print) (First) Robert (Middle) (Last) Pittman

4. DATE OF DEATH (Month) 8 (Day) 24 (Year) 1950

5. SEX Male

6. COLOR OR RACE Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Unknown

8. DATE OF BIRTH Indefinite about 1893

9. AGE last birthday 56? yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) North Carolina

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME Neel Pitman

14. MOTHER'S MAIDEN NAME Anna Wegans

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT AND ADDRESS Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			INTERVAL BETWEEN ONSET AND DEATH
442X	Immediate cause	(a) Chronic myocarditis	Known to us since adm. 8/24/48
131a	Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Psychosis with cardio-renal disease	known to us since admission 8/24/48
		(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/24/, 1948 to 8/24/, 1950, that I last saw the deceased alive on 8/24/, 1950 and that death occurred at 12:50 a.m., from the causes and on the date stated above.

SIGNATURE Jacob Morgenstern (Degree or title) M.D. ADDRESS DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) Removal

DATE THEREOF 8/25/50

NAME OF CEMETERY OR CREMATORY University Med School

LOCATION (City, town, or county) Balt City Md (State)

DATE REC'D BY LOCAL REG. 8/25/50

REGISTRAR'S SIGNATURE L. J. Dr Alba

24. FUNERAL DIRECTOR Frances A Hemsley 578 N Biddle St ADDRESS

98899

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

RECEIVED
AUG 28 1950
BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07901

CERTIFICATE OF DEATH

Reg. Diat. No.....

1. PLACE OF DEATH:

County..... Anundel Co

City or town..... Riviera Beach
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, Institution, or street address where death occurred:

.....

How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State..... Md. County.....

City or town..... Balto
(If outside city or town limits, write RURAL and give nearest town)

Street No..... 107 N. Glover St
(If rural, give LOCATION)

2.(a) If veteran, name war..... none

3.(a) FULL NAME CARRIE HELEN POPP

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife..... John Popp

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) Nov. 18, 1887

8. AGE: Years 62 | Months 9 | Days 8 | If less than one day ..... hrs. ..... min.

9. Birthplace..... Baltimore
(Town, county, and state)

10. Usual occupation..... none

11. Industry or business

FATHER 12. Name..... John Smith

13. Birthplace..... Baltimore

MOTHER 14. Maiden name..... Mary Boltzes

15. Birthplace..... Germany

18. Informant..... Mr John Popp

Address 107 N. Glover St

17. Burial (Burial, cremation, or removal. Which?) Date thereof..... Aug 29/50 (month) (day) (year)

Cemetery or crematory..... Oak Lawn Cem

Location..... Baltimore

18. Funeral director..... Philip Henry & Sons

Address 2024 Orleans St

19. 8/28 1950 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... August 26 1950, at 1:20 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 21 1950, to August 26 1950

and that I last saw her alive on August 25 1950

Immediate cause of death	DURATION
Heart Failure	2 days
Due to..... Hypertension Cardio Vascular	
Due to..... Illness	3 years
Other conditions..... Cerebral Hemorrhage	5 days

443X
932 (Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury Injured at work?

23. SIGNATURE..... J. Brady Smith M.D.
M. D. or other

Address..... Riviera Beach, Md. Date signed..... 8/26/50

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

M

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VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

07902

CERTIFICATE OF DEATH

Reg. Dist. No. 20

1. PLACE OF DEATH: COUNTY ANNE ARUNDEL MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN NUTWELL
LENGTH OF STAY (in this place) LIFE
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND COUNTY A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN NUTWELL
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) MARY (Middle) ELEANOR (Last) PROUT

4. DATE OF DEATH (Month) AUG. (Day) 4 (Year) 1950

5. SEX FEMALE

6. COLOR OR RACE WHITE

7. ~~SINGLE~~, MARRIED, ~~WIDOWED, DIVORCED~~ ~~(Specify)~~ MARRIED

8. DATE OF BIRTH APR. 21. 1876

9. AGE last birthday 74 yrs. If under 1 year Months Days If under 24 hrs. Hours Mfn.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WORK

10b. KIND OF BUSINESS OR INDUSTRY NONE

11. BIRTHPLACE (State or foreign country) MD

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME THOMAS S. NUTWELL

14. MOTHER'S MAIDEN NAME ANNIE DAFFIN NUTWELL

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no

16. SOCIAL SECURITY NO. none

17. INFORMANT R. Glenn Prout

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			INTERVAL BETWEEN ONSET AND DEATH
420.1	Immediate cause	(a) Coronary Thrombosis	15 min
131a	Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Hypertensive CVR Disease	15 yrs
		(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan, 1949, to Aug 4, 1950, that I last saw the deceased alive on 4 Aug, 1950, and that death occurred at 6 30 A m., from the causes and on the date stated above.

SIGNATURE Robert B Sasser (Degree or title) MD ADDRESS Upper Marlboro, Md DATE SIGNED 5 Aug 50

23. BURIAL, ~~CREMATION~~ ~~REMOVAL (Specify)~~ DATE THEREOF Aug 6. 1950 NAME OF CEMETERY OR ~~CREMATORY~~ Friendship Cem LOCATION (City, town, or county) Friendship (State) Md

DATE REC'D BY LOCAL REG. 8/5/50 REGISTRAR'S SIGNATURE D. R. Clayton Dep Local Reg

24. FUNERAL DIRECTOR T. A. Hardesty & Son ADDRESS Gaksville Md.

52086

RECEIVED
AUG 9 1950
BUREAU V. S

Evidence for addition in 18 shown on:

FILM No. G 127 AUG 29 1950

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

07903

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Elvaton
LENGTH OF STAY (in this place) 38 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS Chris Road & Elvaton Drive

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Elvaton.
STREET ADDRESS (If rural give location) Chris Road & Elvaton Drive

3. NAME OF DECEASED (Type or Print) (First) CYRUS (Middle) COLUMBUS (Last) PUMPHREY

4. DATE OF DEATH (Month) August (Day) 21 (Year) 1950

5. SEX M
6. COLOR OR RACE W
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)
8. DATE OF BIRTH July 4, 1883
9. AGE last birthday 67 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) mason
10b. KIND OF BUSINESS OR INDUSTRY contractor
11. BIRTHPLACE (State or foreign country) Anne Arundel Co Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME John Pumphrey
14. MOTHER'S MAIDEN NAME Julia Meeks

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY No. none
17. INFORMANT Idella Pumphrey wife PASADENA, MD.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Carcinoma; primary site Throat (8-29-50 - ams)

148x Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

45P (c)

INTERVAL BETWEEN ONSET AND DEATH years.

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/19, 1950, to 8/21, 1950, that I last saw the deceased alive on 8/19, 1950, and that death occurred at 12:30 A.m., from the causes and on the date stated above.

SIGNATURE Bobby L. Jones, (Degree or title) M.D. ADDRESS Glen Burnie, Md DATE SIGNED 8/21/50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF 8/23
NAME OF CEMETERY OR CREMATORY Glen Haven
LOCATION (City, town, or county) Glen Burnie (State)

DATE REC'D BY LOCAL REG. 8/21
REGISTRAR'S SIGNATURE [signature]
24. FUNERAL DIRECTOR T. W. Singleton ADDRESS

306 V9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
AUG 23 1950
BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH

07904

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH
COUNTY: Anne Arundel Co. — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Anne Arundel General Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Md — COUNTY:
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore
STREET ADDRESS (If rural give location): 1315 Pentwood Rd

3. NAME OF DECEASED (Type or Print): (First) ANTHONY (Middle) (Last) PURCELL

4. DATE OF DEATH: (Month) Aug (Day) 14 (Year) 1950

5. SEX: Male

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: Mar. 10, 1912

9. AGE last birthday: 38 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Lawyer

10b. KIND OF BUSINESS OR INDUSTRY: Professional

11. BIRTHPLACE (State or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Chester F. Purcell

14. MOTHER'S MAIDEN NAME: Grace Nagle

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): World 2

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mrs. Shirley J. Purcell 1315 Pentwood Rd.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

331X

Immediate cause (a) Cerebral Hemorrhage — 9 hrs.

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Hypertension — unknown

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug 14, 11 AM 19 50, to Aug 14, 7 PM 19 50, that I last saw the deceased alive on Aug 14, 19 50, and that death occurred at 7 P.M., from the causes and on the date stated above.

SIGNATURE: George C Bond — (Degree or title) M. D. — ADDRESS: Annapolis Md — DATE SIGNED: 8-15-50

23. BURIAL, CREMATION REMOVAL (Specify): Burial | DATE THEREOF: 8/17/50 | NAME OF CEMETERY OR CREMATORY: Druid Ridge | LOCATION (City, town, or county) (State): Pikesville, Md.

DATE REC'D BY LOCAL REG.: 8/16/50 | REGISTRAR'S SIGNATURE: [illegible] | 24. FUNERAL DIRECTOR: Wm. J. Tuckner & Sons Inc. | ADDRESS: Balto Md

25693

07905

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis Md
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Anne Arundel Gen Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Camberstone Md
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) Florence (Middle) (Last) Randall

4. DATE OF DEATH (Month) Aug. (Day) 2. (Year) 1950

5. SEX Female

6. COLOR OR RACE Col

7. ~~SINGLE~~, MARRIED, ~~WIDOWED, DIVORCED~~, (Specify)

8. DATE OF BIRTH May 6, 1883

9. AGE last birthday 67 yrs. If under 1 year: Months | Days | If under 24 hrs.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE

10b. KIND OF BUSINESS OR INDUSTRY NONE

11. BIRTHPLACE (State or foreign country) Md

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME James Hall

14. MOTHER'S MAIDEN NAME Sarah Jane Kent

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY No. 214-14-2793

17. INFORMANT AND ADDRESS Richard Randall

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Acute Hemorrhagic Myocarditis	1 wk.
591X Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Multiple Absesses of liver & brain	2 wk.
130	(c) Subacute Nephritis c̄ Cystic Degeneration	?

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Chronic Cholecystitis ?

19a. DATE OF OPERATION —

19b. MAJOR FINDINGS OF OPERATION —

20. AUTOPSY? Yes ☑ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) —

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from 7/27/1950, to 8/2/1950, that I last saw the deceased alive on 8/2/1950, and that death occurred at 5:45P m., from the causes and on the date stated above.

SIGNATURE Frank M. Shipley (Degree or title) M.D. ADDRESS 63 College Ave. Annapolis Md. DATE SIGNED 8/3/50

23. BURIAL, ~~CREMATION~~ ~~REMOVAL (Specify)~~ DATE THEREOF Aug 5 1950 NAME OF CEMETERY ~~OR CREMATORY~~ Hanover Star Cem LOCATION (City, town, or county) West River Md (State)

DATE REC'D BY LOCAL REG. Aug 4, 1950 REGISTRAR'S SIGNATURE [signature] 24. FUNERAL DIRECTOR T.A. Hardesty & Son ADDRESS Galesville Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
AUG 7 1950
BUREAU V. S.

Evidence for addition on cause of death shown on Film G128 - 914/50 as

07906

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Crownsville
LENGTH OF STAY (in this place) 3 yrs. 17 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Davidsonville
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) Eugene (Middle) (Last) Rawlings

4. DATE OF DEATH (Month) 8 (Day) 17 (Year) 1950

5. SEX Male

6. COLOR OR RACE Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married

8. DATE OF BIRTH 3/7/11

9. AGE last birthday 39 yrs. If under 1 year: Months — Days — If under 24 hrs.: Hours — Min. —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer

10b. KIND OF BUSINESS OR INDUSTRY Farm Laborer

11. BIRTHPLACE (State or foreign country) Maryland

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME Woodrow Rawlings

14. MOTHER'S MAIDEN NAME Virginia Williams

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) — (If year, give war or dates of service) —

16. SOCIAL SECURITY NO. —

17. INFORMANT AND ADDRESS Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) TB of lungs — Known to us since 5/25/50

Antecedent cause(s) (b) ~~General Paresis~~ — ~~Known to us since adm. 7/31/47~~

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. General Paresis — Known since adm. 7/31/47

19a. DATE OF OPERATION —

19b. MAJOR FINDINGS OF OPERATION (9-14-50 - ams)

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7/31, 1947, to 8/17, 1950, that I last saw the deceased alive on 8/17, 1950, and that death occurred at 9:45 p.m., from the causes and on the date stated above.

SIGNATURE Jacob Morgenstern M.D. (Degree or title) ADDRESS Crownsville, Maryland DATE SIGNED 8/18/50

23. BURIAL, CREMATION, REMOVAL (Specify) — DATE Aug 20 1950 — NAME OF CEMETERY OR CREMATORY Davidsonville Md — LOCATION (City, town, or county) Davidsonville (State) Md

DATE REC'D BY LOCAL REG. August 18, 1950 — REGISTRAR'S SIGNATURE M. E. Joyce

24. FUNERAL DIRECTOR H. A. Hardesty & Son — ADDRESS Galesville

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VS. A15

RECEIVED
SEP 6 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

07907

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH
COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis
LENGTH OF STAY (in this place): 1 day
HOSPITAL OR INSTITUTION OR STREET ADDRESS: U.S. Naval Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis
STREET ADDRESS (If rural give location): Annapolis, Maryland

3. NAME OF DECEASED (Type or Print): (First) Linda (Middle) Ann (Last) REBUSTILLO

4. DATE OF DEATH: (Month) August (Day) 31 (Year) 1950

5. SEX: Female

6. COLOR OR RACE: Filipino

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: 8-30-50

9. AGE last birthday: yrs. — If under 1 year: Months — Days: 1 — If under 24 hrs.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Annapolis, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Andres B. REBUSTILLO

14. MOTHER'S MAIDEN NAME: Juan Espiritus

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Hospital Records.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Postnatal asphyxia and atelectasis	14 hours
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Cystic disease of lung	Congenital
	(c)	

759.0
161a

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Polycystic disease of kidney, congenital

19a. DATE OF OPERATION: - - - -

19b. MAJOR FINDINGS OF OPERATION: - - - - - -

20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): - - -

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: - - -

(CITY OR TOWN) (COUNTY) (STATE): -

TIME OF INJURY (Month) (Day) (Year) (Hour): - - - - - - - - m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR? -

22. I hereby certify that I attended the deceased from 8-30, 19 50, to 8-31, 19 50, that I last saw the deceased alive on 8-31, 19 50, and that death occurred at 5:15 A.m., from the causes and on the date stated above.

SIGNATURE: R.F. Cantrell — (Degree or title): CAPT, MC, USN — ADDRESS: U.S. NAVAL HOSPITAL, ANNAPOLIS, MD. — DATE SIGNED: 8-31-50

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE THEREOF: 9-5-50 — NAME OF CEMETERY OR CREMATORY: U S NAVAL CEMETERY — LOCATION (City, town, or county) (State): ANNAPOLIS, Md

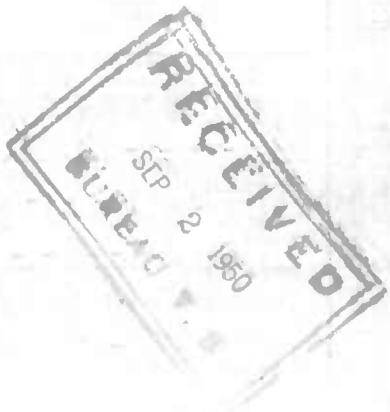
DATE REC'D BY LOCAL REG.: Sept. 1, 1950 — REGISTRAR'S SIGNATURE: [signature] — 24. FUNERAL DIRECTOR: B.L. Hopping & Son — ADDRESS: ANNAPOLIS

2-0-8-30-0-16-1-40-3

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15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MARYLAND STATE DEPARTMENT OF HEALTH

07908

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A

1. PLACE OF DEATH
COUNTY: Anne Arundel — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Annapolis Co. Jail

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis
STREET ADDRESS (If rural, give location): 146 Charles St.

3. NAME OF DECEASED (Type or Print): (First) CECIL (Middle) (Last) ROBARDS

4. DATE OF DEATH: (Month) August (Day) 30 (Year) 1950

5. SEX: Male

6. COLOR OR RACE: White

7. ~~SINGLE~~, MARRIED, ~~WIDOWED~~, ~~DIVORCED~~ (Specify)

8. DATE OF BIRTH: 6-26-1910

9. AGE last birthday: 40 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cement Pump man

10b. KIND OF BUSINESS OR INDUSTRY: Bridge Builder

11. BIRTHPLACE (State or foreign country): Rondo Ark.

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: J. W. Robards

14. MOTHER'S MAIDEN NAME: Annie Howard

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Holly Robards Wife Annapolis Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

581.0 Immediate cause (a) Edema of brain

1240 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Fatty liver

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY: (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED

Stanley B. Duncalfe, M. D. — 700 Fleet St. — August 30, 1950

23. ~~BURIAL~~, CREMATION, REMOVAL (Specify) | DATE THEREOF: Aug 30 1950 | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State): Marianna Lee Co. Ark.

DATE REC'D BY LOCAL REG.: Aug. 31, 1950 | REGISTRAR'S SIGNATURE: [signature] | 24. FUNERAL DIRECTOR | ADDRESS: John W. Taylor Son Annapolis Md.

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BUREAU V. S

07909

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 27

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY: Anne Arundel; STATE: MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Ft Geo G Meade, ; LENGTH OF STAY (in this place): 2 months; HOSPITAL OR INSTITUTION OR STREET ADDRESS: U. S. ARMY HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland; COUNTY: Anne Arundel; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: ; STREET ADDRESS (If rural give location):

3. NAME OF DECEASED (Type or Print): (First) GREGG (Middle) ALAN (Last) RUDY

4. DATE OF DEATH: (Month) August (Day) 11 (Year) 1950

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: 20 Feb 1950

9. AGE last birthday: ~~5/12~~ yrs. If under 1 year: Months 5 Days 21 If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY? America

13. FATHER'S NAME: Wilbur D. Rudy (Capt)

14. MOTHER'S MAIDEN NAME: Shirley Ann Burg

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT: Wilbur D. Rudy

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

744.1 **Immediate cause** (a) Myotonia congenital

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

157m (b)

(c)

INTERVAL BETWEEN ONSET AND DEATH

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN):

(COUNTY):

(STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour): m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on 11 Aug 1950, and that death occurred at 0700 A.m., from the causes and on the date stated above.

SIGNATURE: Francis M. Fitts — (Degree or title): Col., MC — ADDRESS: FT G G Meade, Md — DATE SIGNED: 15 Aug 50

FRANCIS M. FITTS

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE THEREOF: 16 Aug 50 — NAME OF CEMETERY OR CREMATORY: Post Cemetery — LOCATION (City, town, or county) (State): Ft George G Meade, Maryland

DATE REC'D BY LOCAL REG.: 15 Aug 50 — REGISTRAR'S SIGNATURE: E. K. BURNSIDE Capt., MSC

21. FUNERAL DIRECTOR: F. R. Griepp Capt., Chap corp — ADDRESS: Ft Meade, Md

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AUG 18 1950
BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

07910

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis | LENGTH OF STAY (in this place) 7 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Annapolis

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Alexandria — COUNTY Virginia
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Virginia
STREET ADDRESS (If rural give location) arlington

3. NAME OF DECEASED (Type or Print): (First) Olaf. (Middle) (Last) Sangstad.

4. DATE OF DEATH: (Month) 8 (Day) 19 (Year) 1950

5. SEX Male. | 6. COLOR OR RACE White | 7. ~~SINGLE~~, MARRIED, ~~WIDOWED, DIVORCED~~, (Specify) | 8. DATE OF BIRTH Oct 25 1868 | 9. AGE last birthday 81 yrs. | If under 1 year: Months, Days | If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher + Artist | 10b. KIND OF BUSINESS OR INDUSTRY Ret. | 11. BIRTHPLACE (State or foreign country) Westby Wisconsin | 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Dr. Christian Sangstad | 14. MOTHER'S MAIDEN NAME Rondena Johnson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) unknown | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. — | 17. INFORMANT Mrs. Eugenie Sangstad

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | INTERVAL BETWEEN ONSET AND DEATH

420.1 **Immediate cause** (a) Coronary Disease

94a **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☑ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE [signature] (Degree or title) ADDRESS [illegible] DATE SIGNED 8/19/50.

23. BURIAL, CREMATION, REMOVAL (Specify) | DATE THEREOF Aug 22 1950 | NAME OF CEMETERY OR CREMATORY Rock Creek | LOCATION (City, town, or county) Washington (State) DC.

DATE REC'D BY LOCAL REG. 8-19-1950 | REGISTRAR'S SIGNATURE [signature] | 24. FUNERAL DIRECTOR B Wheatley Funeral Home ADDRESS Alexandria, Va V3491

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BUREAU OF S

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS. A15A

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

07911

Reg. Dist. No. 25

1. PLACE OF DEATH: COUNTY Ann Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Curtis Bay
LENGTH OF STAY (in this place) 5 hrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Personal Office U.S.C. Guard - Curtis Bay

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore
STREET ADDRESS (If rural, give location) 2636 - N. Charles St.

3. NAME OF DECEASED (Type or Print) (First) James (Middle) J. (Last) Seaborn Sr.

4. DATE OF DEATH (Month) Aug. (Day) 18 (Year) 1950

5. SEX Male.

6. COLOR OR RACE White

7. ~~SINGLE, MARRIED, WIDOWED~~, DIVORCED, (Specify)

8. DATE OF BIRTH 8/10/96

9. AGE last birthday 54 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Safety Engineer.

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Alabama, U.S.A.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME David Seaborn

14. MOTHER'S MAIDEN NAME Elizabeth Sanders.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) 5/6/18 to 8/6/19

16. SOCIAL SECURITY NO. —

17. INFORMANT U.S. Coast Guard Records.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
42D, Immediate cause	(a) Coronary Occlusion	Sudden
94a Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION —

19b. MAJOR FINDINGS OF OPERATION —

20. AUTOPSY? Yes ☐ No ☑

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. —

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) — m.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☑ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Gustave H. Fischer Md. assistant Medical Exam. Glen Burnie, Md. 8/18/50

23. BURIAL, CREMATION REMOVAL (Specify) Burial

DATE THEREOF 8/22/50

NAME OF CEMETERY OR CREMATORY Baltimore National

LOCATION (City, town, or county) (State) Balto Md

DATE REC'D BY LOCAL REG. 8/21/50

REGISTRAR'S SIGNATURE A.W. Hedrick

24. FUNERAL DIRECTOR L.J. Kuck, 5305 Harford Rd. ADDRESS

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MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Fairhaven
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Nr. St. Margarets

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Nr. ~~Fairhaven~~ St. Margarets
STREET ADDRESS (If rural give location) Log Inn

3. NAME OF DECEASED (Type or Print) (First) Marjorie (Middle) Emary (Last) Simpson
4. DATE OF DEATH (Month) Aug. (Day) 26 (Year) 1950
5. SEX Female
6. COLOR OR RACE W.
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)
8. DATE OF BIRTH 12-10-10
9. AGE last birthday 39 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE.
10b. KIND OF BUSINESS OR INDUSTRY None
11. BIRTHPLACE (State or foreign country) A. A. Co. Md
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Wm. T Emary.
14. MOTHER'S MAIDEN NAME Marie A. Koch.
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) 1/8 (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Arlene B. Emary.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

929.8 183

Immediate cause (a) Drowning.

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) Annapolis (COUNTY) Anne Arundel (STATE) Md.
TIME OF INJURY (Month) Aug (Day) 25 (Year) 1950 (Hour) 11 p.m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR? Went for a swim and accidentally drowned (10-5-50 akc)

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE C. Fairhaven (Degree or title) MB. ADDRESS Easport, Md. DATE SIGNED Aug. 27-1950

23. BURIAL, ~~CREMATION~~ ~~REMOVAL~~ (Specify) DATE THEREOF 8/28/50 NAME OF CEMETERY OR CREMATORY St. Anne's LOCATION (City, town, or county) Annapolis, (State) Md.

DATE REC'D BY LOCAL REG. Aug. 28, 1950 REGISTRAR'S SIGNATURE [signature] 24. FUNERAL DIRECTOR John M. Layton & Son ADDRESS Annapolis Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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VS. A15A

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AUG 29 1950
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MARYLAND STATE DEPARTMENT OF HEALTH

07913

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 26

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH
COUNTY A.A.Co. — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural, Churchton (Broadwater Point.)
LENGTH OF STAY (In this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Md. — COUNTY A.A. Co.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural- Churchton, Md. - Broadwater Pt.
STREET ADDRESS (If rural give location) Rural

3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)	4. DATE OF DEATH	(Month)	(Day)	(Year)
	A.	LAWRENCE	SMITH		AUG.	23,	1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year Months	Days	If under 24 hrs. Hours	Min.
Male	White	Married	Oct. 10, 1895	54 yrs.	10	13		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Mechanical Engineer		Plain City, Ohio	U.S.A.

13. FATHER'S NAME: Archibald Smith

14. MOTHER'S MAIDEN NAME: Emily Scott

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. ?

17. INFORMANT: Mrs. Ruth Smith

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
420.1 Immediate cause	(a) Coronary disease	one hour.
94a Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
G. Lee Laird		Chesapeake St.	8/23/50

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Removal	Aug. 23/50		Washington, D.C.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Aug. 23, 1950	J. B. Dent	Martin W. Hysong Co.	Wash. D.C.

V2293

VS. A15A

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AUG 28 1950
BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

07914

Reg. Dist. No. 20

1. PLACE OF DEATH: COUNTY aa MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Fair Haven
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Wash. D.C. COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) John B. (Middle) Staunton (Last)

4. DATE OF DEATH (Month) 8 (Day) 25 (Year) 1950

5. SEX M

6. COLOR OR RACE W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Divorced

8. DATE OF BIRTH 2-27-1901

9. AGE last birthday 49 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pressman Printer

10b. KIND OF BUSINESS OR INDUSTRY Government

11. BIRTHPLACE (State or foreign country) Washington, D.C.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Francis Joseph Staunton

14. MOTHER'S MAIDEN NAME Mary Elizabeth Truman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT AND ADDRESS Mrs. Lillian F. Long Washington D.C.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1 Immediate cause (a) Coronary embolism

Antecedent cause(s)

94a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

INTERVAL BETWEEN ONSET AND DEATH 2 min

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION —

19b. MAJOR FINDINGS OF OPERATION —

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify) —

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ....., 19....., to ....., 19....., that I last saw the deceased alive on ....., 19....., and that death occurred at 11 40P m., from the causes and on the date stated above.

SIGNATURE H Howard (Degree or title) ADDRESS Owings Md. DATE SIGNED 8/27/50

23. BURIAL, CREMATION, REMOVAL (Specify) Burial DATE 8/29/50 NAME OF CEMETERY OR CREMATORY Houstown Cem. LOCATION (City, town, or county) Houstown (State) Md.

DATE REC'D BY LOCAL REG. 8/26/50 REGISTRAR'S SIGNATURE M. Clayton Deputy Registrar

24. FUNERAL DIRECTOR Robt A. Humphrey ADDRESS Bethesda Md.

392.14

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
AUG 29 1950
BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

07915

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The consect age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY Q a. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Severna Park
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Cedar Crest Nursing Home

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Md COUNTY Aa.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Eastport
STREET ADDRESS (If rural, give location) 622 Sixth St.

3. NAME OF DECEASED (Type or Print) (First) Alice (Middle) E. (Last) Stevens

4. DATE OF DEATH (Month) 8 (Day) 21 (Year) 1950

5. SEX F

6. COLOR OR RACE W.

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

8. DATE OF BIRTH 7-21-1861

9. AGE last birthday 89 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none

10b. KIND OF BUSINESS OR INDUSTRY Home

11. BIRTHPLACE (State or foreign country) Maryland

12. CITIZEN OF WHAT COUNTRY U. S. A.

13. FATHER'S NAME Amos W. Worthington

14. MOTHER'S MAIDEN NAME Harriet Hall

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT AND ADDRESS Mrs Norman Bell Eastport Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

422.1 Immediate cause (a) Myocarditis chr — Interval between Onset and Death Several yrs

932 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerosis

19a. DATE OF OPERATION — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY — (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March 1, 1950, to Aug 21, 1950, that I last saw the deceased alive on Aug 21, 1950, and that death occurred at 11 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) — ADDRESS — DATE SIGNED

George C Basil M.D. Annapolis Md 8.22.50

23. BURIAL, CREMATION, REMOVAL (Specify) — DATE THEREOF 8-24-50 — NAME OF CEMETERY OR CREMATORY Mt Harmony — LOCATION (City, town, or county) (State) Calvert Co Md

DATE REC'D BY LOCAL REG. Aug. 24, 1950 — REGISTRAR'S SIGNATURE — FUNERAL DIRECTOR John W. Sayton Son — ADDRESS Annapolis Md.

RECEIVED
AUG 25 1950
BUREAU V. I.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

07916

Reg. Dist. No.....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH · COUNTY Annie Arundel County MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE Maryland COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Freetown · LENGTH OF STAY (In this place) Life	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Freetown A.A.Co., Md.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Rural-Freetown, A.A.Co.,	STREET ADDRESS (If rural give location) Rural Freetown A.A.Co., Md.

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Florence	S.	Stewart	8	16	1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Female	Colored	Married	10/6/1901	48 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		A.A.Co., Md.	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Tomny Fisher	Harriett Spencer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
No	None	Hiram Stewart

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

443X **Immediate cause** (a) Cerebral Hemorrhage — 15 days

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

932 (b) hypertensive Cardio-vascular disease — unknown

(c) Congestive Liart failure & ascites — 6 months

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Jan 15, 1950, to Aug 16, 1950 that I last saw the deceased alive on Aug 15, 1950, and that death occurred at 2:45 P m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Randall M. McLaughlin	M.D.	Pasadena, Md.	August 16, 1950

23. BURIAL, CREMATION · REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	8/20/1950	Mary Ned Ct	A.A. Co., Md

DATE RECD BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
8/18/50	A.W. Hedrick	D.L. Brown & Son	108 W. Montgomery St

VS. A15

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

07917

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY ANNE ARUNDEL MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN SEVERN (RURAL) LENGTH OF STAY (in this place) 7 YRS.
HOSPITAL OR INSTITUTION OR STREET ADDRESS DISNEY, RD. Nr. ANNAPOLIS, RD

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND COUNTY A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN SEVERN (RURAL)
STREET ADDRESS (If rural, give location) DISNEY, RD. Nr ANNAPOLIS RD.

3. NAME OF DECEASED (Type or Print) (First) EMMA (Middle) V. (Last) STRINE.

4. DATE OF DEATH (Month) AUG. (Day) 16 (Year) 1950

5. SEX FEMALE

6. COLOR OR RACE WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) DIVORCED

8. DATE OF BIRTH APRIL 8, 1870

9. AGE last birthday 80 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWORK (RETIRED)

10b. KIND OF BUSINESS OR INDUSTRY OWN HOME

11. BIRTHPLACE (State or foreign country) UNION BRIDGE CARROLL CO. MD

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME JACOB STRINE

14. MOTHER'S MAIDEN NAME SUSAN STRINE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. NONE.

17. INFORMANT AND ADDRESS MRS. BLANCHE SHARER, 225 WEST SIDE AVE HAGERSTOWN, MD.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			INTERVAL BETWEEN ONSET AND DEATH
170X	Immediate cause	(a) Cardio-Vascular Disease	2 yrs.
50	Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Hypertension — Arterio Sclerosis	10 yrs.
		(c) Cancer both breast. Arthritis	5 yrs.

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. —

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURRED While at Work ☐ Not While At work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan -, 1940, to Aug. 16, 1950, that I last saw the deceased alive on Aug. 16, 1950, and that death occurred at 5.05A. m., from the causes and on the date stated above.

SIGNATURE Chas. L. Ball Jr (Degree or title) MD ADDRESS Linthicum Hgts. DATE SIGNED 8/16/50

23. BURIAL, CREMATION REMOVAL (Specify) BURIAL DATE THEREOF AUG 18 1950 NAME OF CEMETERY OR CREMATORY SAM'S CREEK LOCATION (City, town, or county) NEW WINDSOR (State) MD.

DATE REC'D BY LOCAL REG. 8/17/50 REGISTRAR'S SIGNATURE L. J. De Alba

24. FUNERAL DIRECTOR Thomas W Singleton ADDRESS Glen Burnie Md

RECEIVED
AUG 21 1950
BUREAU U. S

Evidence for addition in #18 shown on:

FILM No. G 128 SEP 25 1950

07918

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severn River
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY A.A.
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore (Brooklyn)
STREET ADDRESS (If rural, give location) 562 Ballman Avenue

3. NAME OF DECEASED (Type or Print) (First) STEWART (Middle) (Last) TAYLOR
4. DATE OF DEATH (Month) August (Day) 20 (Year) 1950

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) M
8. DATE OF BIRTH 6/20/1912
9. AGE last birthday 38 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pumpman
10b. KIND OF BUSINESS OR INDUSTRY Merritt, Chap. & Scott
11. BIRTHPLACE (State or foreign country) W. Va.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME James J. Taylor
14. MOTHER'S MAIDEN NAME Lota Weese

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY No.
17. INFORMANT Family - Same

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

929.8 Immediate cause (a) Drowning

183 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Deceased apparently missed step and fell overboard while working on the Severn River Bridge at approximately (c) 7:00 p.m. on August 20, 1950 (9/25/50 akc)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) River
(CITY OR TOWN) (COUNTY) aa (STATE) Severn River (Severn River Bridge) Md.
TIME OF INJURY (Month) (Day) (Year) (Hour) August 20, 1950 m.
INJURY OCCURRED While at work ☒ Not while at work ☐
HOW DID INJURY OCCUR? see above

22. *I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE William V Lovitt (Degree or title) M.D. ADDRESS 700 Fleet Street DATE SIGNED 8-21-50

23. BURIAL, CREMATION REMOVAL (Specify) B
DATE THEREOF 8/23/50
NAME OF CEMETERY OR CREMATORY Glen Haven
LOCATION (City, town, or county) (State) Glen Burnie

DATE REC'D BY LOCAL REG. 8/23/50
REGISTRAR'S SIGNATURE A. W. Hedrick
24. FUNERAL DIRECTOR James L. McCarney ADDRESS - 130 E. Fort Ave.

JT

356 V9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A

M

I

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

07919

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN West Annapolis
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 701 Severn Ave

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN West Annapolis
STREET ADDRESS (If rural, give location) 701 Severn Ave.

3. NAME OF DECEASED (Type or Print) (First) JOSEPH (Middle) ALBERT (Last) TAYMAN

4. DATE OF DEATH (Month) Aug. (Day) 13, (Year) 1950 19

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed
8. DATE OF BIRTH March 29, 1863
9. AGE last birthday 87 yrs. If under 1 year Months 4 Days 14 If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WATCHMAN
10b. KIND OF BUSINESS OR INDUSTRY Auto Bridge
11. BIRTHPLACE (State or foreign country) Anne Arundel Co., Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME John Henry Tayman
14. MOTHER'S MAIDEN NAME Ellen Sears

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT AND ADDRESS Mr Wm. Tayman West Annapolis, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Myocarditis Chr. Ex Myocardial — INTERVAL BETWEEN ONSET AND DEATH: Small

422.1 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Insufficiency — years

93d (c) Arteriosclerosis Genuine Signal — Small years

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug 6, 1950, to Aug 13, 1950, that I last saw the deceased alive on Aug 12, 1950, and that death occurred at 6 47 m., from the causes and on the date stated above.

SIGNATURE George C Basil (Degree or title) M D ADDRESS Annapolis Md DATE SIGNED 8-14-50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF Aug. 15, 1950
NAME OF CEMETERY OR CREMATORY Cedar Bluff Cemetery
LOCATION (City, town, or county) (State) Annapolis, Md.

DATE REC'D BY LOCAL REG. August 15, 1950
REGISTRAR'S SIGNATURE [signature]
24. FUNERAL DIRECTOR B.L. Hopping and Son ADDRESS Annapolis, Md.

60253

RECEIVED
AUG 16 1950
BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

07320

CERTIFICATE OF DEATH

Reg. Dist. No. 28

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: 113 Ridgely ave
LENGTH OF STAY (in this place): 23 yrs
STATE: MARYLAND
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 113 Ridgely ave

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Annapolis
COUNTY: null
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN:
STREET ADDRESS (If rural, give location): 113 Ridgely ave annapolis md

3. NAME OF DECEASED (Type or Print): (First) Carey (Middle) E (Last) Thomas

4. DATE OF DEATH: (Month) August (Day) 28 (Year) 1950

5. SEX: Female

6. COLOR OR RACE: Colord

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

8. DATE OF BIRTH: Sept 18. 1880

9. AGE last birthday: 69 yrs. If under 1 year: Months 11, Days 28. If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY: Hous Keep

11. BIRTHPLACE (State or foreign country): montgomery Co

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Charles A Howard

14. MOTHER'S MAIDEN NAME: millie Dublin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown):

(If year, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Benjamond Franklin Thomas

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Cerebral Hemorrhage	4 days
422.1 Antecedent cause(s)		
93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) arteriosclerotic cardiovascular disease	10 yrs
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN):

(COUNTY):

(STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 40, to Aug 28 50, that I last saw the deceased alive on Aug 27 50, and that death occurred at 12 50 a m., from the causes and on the date stated above.

SIGNATURE: S Bozuda (Degree or title): M D ADDRESS: Annapolis Md DATE SIGNED:

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE: August 30

NAME OF CEMETERY OR CREMATORY: Sandy Spring md

LOCATION (City, town, or county): montgomery Co (State):

DATE REC'D BY LOCAL REG.: Aug 28

REGISTRAR'S SIGNATURE: M E Joyce

24. FUNERAL DIRECTOR: Robert L Snowden

ADDRESS: Rockville Md

52086

RECEIVED
SEP 6 1950
BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH

07921

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 25

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: A. A. Co. — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Curtis Bay P. O.
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 151 Carvel Beach Rd.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Md. — COUNTY: A. A. Co.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Curtis Bay P. O.
STREET ADDRESS (If rural, give location): 151 Carvel Beach Rd. Zone 26

3. NAME OF DECEASED (Type or Print): (First) Walter (Middle) Chauncey (Last) Thomas

4. DATE OF DEATH: (Month) Aug. (Day) 1 (Year) 1950

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married

8. DATE OF BIRTH: Sept. 25, 1891

9. AGE last birthday: 58 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Owner (rtd)

10b. KIND OF BUSINESS OR INDUSTRY: Boat Yard

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: George Thomas

14. MOTHER'S MAIDEN NAME: Julia Abbott

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service)

16. SOCIAL SECURITY No.

17. INFORMANT: Mrs. Walter C Thomas 151 Carvel Beach Rd.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331X — Immediate cause (a) Cerebral Hemorrhage — Interval between onset and death: One week

83a — Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Escential Hypertention. — 3 years

(c) Arterial Sclerosis — 2.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY — (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 1950, to Aug. 1, 1950, that I last saw the deceased alive on Aug 1, 1950, and that death occurred at 7 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Thos. H. Phillips M.D. — ADDRESS: 3307 Edmondson Ave Balto. Md. — DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE THEREOF: 8/4/50 — NAME OF CEMETERY OR CREMATORY: Druid Ridge Cem. — LOCATION (City, town, or county) (State): Pikesville, Md.

DATE REC'D BY LOCAL REG.: 8/3/50 — REGISTRAR'S SIGNATURE: A. W. Hedrick

24. FUNERAL DIRECTOR: Wm. J. Pickner & Sons — ADDRESS: Balto Md.

JT

15641

07922

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Crownsville
LENGTH OF STAY (in this place) 1 year 2 mos
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Somerset
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Upper Hill
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print) (First) Daniel (Middle) Tinley (Last) Waters
4. DATE OF DEATH (Month) 8/10/50 (Day) (Year) 19

5. SEX male
6. COLOR OR RACE colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) separated
8. DATE OF BIRTH 7/27/95
9. AGE last birthday 55 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur
10b. KIND OF BUSINESS OR INDUSTRY none self
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Nelson N. Waters
14. MOTHER'S MAIDEN NAME Henrietta Bowser

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) xxxxxxxxxxxxxxxxxxxx
16. SOCIAL SECURITY NO. xxxxxxxx
17. INFORMANT Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
025x Immediate cause	(a) General Paresis	known since
30b Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	6/12/49
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION none
19b. MAJOR FINDINGS OF OPERATION none
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) none
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) none (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) none m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR? none

22. I hereby certify that I attended the deceased from 6/12/49, 19....., to 8/10/50, 19....., that I last saw the deceased alive on 8/10/50, 19....., and that death occurred at 3:35 P. m., from the causes and on the date stated above.

SIGNATURE Jacob Morgenstern M.D. (Degree or title) ADDRESS Crownsville, Md. DATE SIGNED 8/10/50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF 8-14-1950
NAME OF CEMETERY OR CREMATORY Upper Hill
LOCATION (City, town, or county) (State) Upper Hill, Md.

DATE REC'D BY LOCAL REG. August 10, 1950
REGISTRAR'S SIGNATURE M. E. Joyce
24. FUNERAL DIRECTOR Charles Hard ADDRESS Marion Station, Md.

42099

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
SEP 6 1950
BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A

1. PLACE OF DEATH: COUNTY Anne Arundel; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Millersville; MARYLAND; LENGTH OF STAY (in this place) two months; HOSPITAL OR INSTITUTION OR STREET ADDRESS Route 301

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY St. Mary's; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Mechanicsville; STREET ADDRESS (If rural give location) ✓

3. NAME OF DECEASED (Type or Print): (First) Baby boy (Middle) (Last) Young.

4. DATE OF DEATH: (Month) Aug. (Day) 25 (Year) 1950

5. SEX: Male

6. COLOR OR RACE: Black

7. SINGLE, MARRIED, ~~WIDOWED~~, ~~DIVORCED~~, (Specify): Single

8. DATE OF BIRTH: 8/24/50

9. AGE last birthday: yrs. | If under 1 year: Months | Days | If under 24 hrs.: Hours 20 | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Unknown.

14. MOTHER'S MAIDEN NAME: Mary Catherine Young

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: —

17. INFORMANT: St. Mary's County Health Record

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
776X Immediate cause	(a) Prematurity (7 months gestation)	Sudden
159 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. —

19a. DATE OF OPERATION: none | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Gustave F. Taubert M.D.	Assistant Medical Examiner	Glen Burnie Md.	8/25/50

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	8/25/50		Mechanicsville Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
8/25/50	L. J. DeAlba	(Health Nurses)	Leonardtown Md.

RECEIVED
AUG 28 1950
BUREAU V. S